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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED SEP 8 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28388

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 833

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, S. Campbell Twp.
c. LENGTH OF STAY (in this place): 1yr 4mos 28das
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Medical Center for Federal Prisoners

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Massachusetts
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boston
d. STREET ADDRESS (If rural, give location): Unknown

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3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle): B.
c. (Last): Van Riper

4. DATE OF DEATH (Month) (Day) (Year): August 31, 1953

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 0
8. DATE OF BIRTH: Feb. 29, 1920
9. AGE (In years last birthday): 33 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator
10b. KIND OF BUSINESS OR INDUSTRY: Building Service
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Joseph Van Riper
13b. MOTHER'S MAIDEN NAME: Goldy (?) Van Riper
14. NAME OF HUSBAND OR WIFE: - - - - - - - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 11-19-41 to 11-1-45
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: FILE: M.C.F.P., Springfield, Missouri

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyperthermia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Acute brain syndrome of unknown cause
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Catatonic schizophrenia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 7888
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): - - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): - - - - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): - - - - - - - - - - - -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: - - - - - - - - - - - -

22. *I hereby certify that* the Medical Staff *I attended the deceased from* April 3, 1952, *to* Aug. 31, 1953, *that I last saw the deceased alive on* Aug. 31, 1953, *and that death occurred at* 10:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE E. C. Rinck (Degree or title) E. C. RINCK, M.D., Clinical Director
23b. ADDRESS Medical Center for Fed. Prisoners, Springfield, Mo.
23c. DATE SIGNED 9-2-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9/3/1953
24c. NAME OF CEMETERY OR CREMATORY: - - - - - -
24d. LOCATION (City, town, or county) (State): Newark, New Jersey

DATE REC'D BY LOCAL REG.: 9-5-53
REGISTRAR'S SIGNATURE: Edith Williamson
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: AYRE-GOODWIN, Inc., Springfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

SEP 17 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4594

P. O. Address Springfield, Missou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.