No. 300
10-48

FILED NOV 23 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38230

BIRTH NO. _____ REG. DIST. NO. 1132 PRIMARY REG. DIST. NO. 5108 Registrar's No. 35

1. PLACE OF DEATH
a. COUNTY Benton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Williams
c. LENGTH OF STAY (in this place) 35 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 mi SW of Cole Camp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Benton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Williams
d. STREET ADDRESS (If rural, give location) 3 mi SW of Cole Camp

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Reinhold	Herman	Kupfer	Nov. 16 1953

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	married	Oct 3 1869	84	1 / 13	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Ferdinand Kupfer	Augusta Reinert	Ella Anna Kilker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS John Kupfer, Meredosia Ill.

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 5-6 yr.
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	4201	YES ☐ 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 I attended the deceased from* Nov, 19__, *to* Nov, 19__, *that I last saw the deceased alive on* Nov, 19__, *and that death occurred at* 3:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold B. Wachtel D.O.	Cole Camp Mo	11/17/53

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 19 '53	St Pauls	Cole Camp Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
Nov 19 1953	E L Erickson 394	Harold Perry	Cole Camp, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Harold Penn

Licensed Embalmer No. 4097

P. O. Address Cole Camp, Mo

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.