

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4257**

FILED MAR 9 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **100** PRIMARY REG. DIST. NO. **3018** Registrar's No. **15**

1. PLACE OF DEATH a. COUNTY <b>DENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>DENT</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SALEM</b>		c. CITY OR TOWN <b>SALEM</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>5 yrs</b>		e. STREET ADDRESS (If rural, give location) <b>02ARK HOTEL-5th STREET</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>KNOX NURSING HOME</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>WILLIAM</b>	b. (Middle) <b>THOMAS</b>	c. (Last) <b>HAPPEL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 21 1956</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>OCT. 29, 1876</b>	9. AGE (In years last birthday) <b>79</b>	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) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>DENT COUNTY, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>PETER HAPPEL</b>	13b. MOTHER'S MAIDEN NAME <b>VIRGINIA BROYLES</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>S.E. HAPPEL</b>	ADDRESS <b>SEATON, MO.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Heart Disease</b>		<b>unknown</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>operated</b> DUE TO (c) <b>arteriosclerosis</b>		<b>unknown</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>H201</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>no operation</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **Jan 12, 1956** to **Feb 12, 1956** that I last saw the deceased alive on **Feb 13, 1956** and that death occurred at **10 A.** m., from the causes and on the date stated above.

23a. SIGNATURE <b>L. H. Hunt M.D.</b>	(Degree or title)	23b. ADDRESS <b>Salem, Mo</b>	23c. DATE SIGNED <b>2/22/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>FEB. 23, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MORRISON CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>DENT COUNTY MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>2-22-56</b>	REGISTRAR'S SIGNATURE <b>R. E. Mitchell, Jr. by Mrs. Blackwell - Camp</b>	515- 25. FUNERAL DIRECTOR'S SIGNATURE <b>Blackwell - Camp</b>	ADDRESS <b>Salem, Mo.</b>
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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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Max L. Waugh*

Licensed Embalmer No. *4170*

P. O. Address *Salem, Ind.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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