

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 7 1956

State File No. **12407**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **485**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution—residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		e. STREET ADDRESS (If rural, give location) 1308 S. 16th St.	

3. NAME OF DECEASED (Type or Print) a. (First) LAURA b. (Middle) KEPLINGER c. (Last) KEPLINGER			4. DATE OF DEATH (Month) (Day) (Year) April 23, 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 12, 1882		9. AGE (In years last birthday) Months Days 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and State or Foreign Country) Buchanan County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William W. Payne		13b. MOTHER'S MAIDEN NAME Edna Mae Gist		14. NAME OF HUSBAND OR WIFE Oscar L. Keplinger	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. 491-09-4728	17. INFORMANT'S SIGNATURE OR NAME ADDRESS John W. Keplinger, 3005 St. Joseph, St. Joseph,		
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Bleeding</p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nutritional deficiency with generalized capillary DUE TO (c) permeability</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ASHD = heart failure; Toxic thyroid; non-union, old fracture</p>			<p>INTERVAL BETWEEN ONSET AND DEATH (in months) 36-48</p> <p>months</p>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331x		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)	
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?	

22. I hereby certify that I attended the deceased from **Jan. 1956**, to **April 23, 1956**, that I last saw the deceased alive on **April 23, 1956**, and that death occurred at **9:00** **Caryl A. Potter Jr. M. D.** of the causes and on the date stated above.

23a. SIGNATURE Caryl A. Potter Jr. M.D.		23b. ADDRESS Physicians & Surgeons Bldg. St. Joseph, Mo.	23c. DATE SIGNED 4/25/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 4/26/1956	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. May 3, 1956	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Heston-Bourman St. Joseph, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Al Potter

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 *James P. Hawkins*

Licensed Embalmer No. *45*

P. O. Address *319 So 10th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.