Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004588
STATE FILE NUMBER

FILED MAR 16 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 259

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Joseph Hosp. — Length of stay in Ib: 1 Day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 701 Pendleton St. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Louis Middle: Walter Last: Hupp Jr.

4. DATE OF DEATH: Month: March Day: 9, Year: 1959

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 9,1959
9. AGE (In years last birthday): — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 2 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): St. Joseph, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Louis Walter Hupp Sr.
13b. MOTHER'S MAIDEN NAME: Jenny Elizabeth Williams
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Louis W. Hupp, 701 Pendleton St. Address: City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (1½ lb) — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): undetermined
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 776X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-9-59, to 3-9-59 and last saw her/him alive on 3-9-59
Death occurred at 5:25 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Clement C. DuMont M.D. (Degree or title)
22b. ADDRESS: St. Joseph Mo
22c. DATE SIGNED: 3-11-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: March 11,'59
23c. NAME OF CEMETERY OR CREMATORY: Ashland Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Missouri

24. FUNERAL DIRECTOR: Wm. H. Alexander ADDRESS: St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: Mar. 11, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clarke Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. Clement C. DuMont
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 John H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph

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.