

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031527

FILED VS OCT 13 1959

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>BUCHANAN</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>516 S. 17th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Hupp</u> Last <u>Hupp</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/29/59</u>	9. AGE (last birthday) <u>—</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo U S A</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>Louis Hupp</u>			13b. MOTHER'S MAIDEN NAME <u>Virginia Williams</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Louis Hupp 516 S. 17</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (15 oz)</u>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u> Month, Day, Year <u>—</u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>9-29-59</u> to <u>9-29-59</u> and last saw her/him alive on <u>9-29-59</u> Death occurred at <u>5:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Clement P. Sherman M.D.</u>				22b. ADDRESS <u>St. Joseph, Mo</u>			22c. DATE SIGNED <u>9-30-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 30-'59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Joseph, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Wm. H. Alexander</u>			ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>			

DOCUMENT

BY AFFIDAVIT OF C.S. T.M. / C.S. DuMont Medical Certification

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm. 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 conform 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.