

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020882

STATE FILE NUMBER

AMENDED

Registration District No. 116 Primary Registration District No. 5434 Registrar's No. 169

FILED JUL 10 1961

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. John's Township</u>		Length of stay in 1b <u>6 mo.</u>	c. CITY OR TOWN <u>Washington</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Washington R.2.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.2.</u>
3. NAME OF DECEASED (Type or print) First <u>Samuel E.</u> Middle <u>Rupp</u> Last <u>Rupp</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1893</u>
9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm Topeka, Kansas</u>	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Mrs. Arletia F. Rupp</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>Mrs. Arletia F. Rupp Washington, Mo.</u>	
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>Cerebral Metastasis</u> DUE TO (b) <u>Carcinoma of the Colon</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 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> Month, Day, Year <u></u> a.m. <u></u> p.m. <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>April 1961</u> to <u>July 5 61</u> and last saw <u>him</u> alive on <u>July 3, 1961</u> Death occurred at <u>2100 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James A. Shea M.D.</u>		22b. ADDRESS <u>Herald MO</u>	
22c. DATE SIGNED <u>7/6/61</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 7, 1961</u>	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery Washington Missouri</u>	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS <u>Nieburg &amp; Voth, Inc., Washington, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>7/6/61</u>		26. REGISTRAR'S SIGNATURE <u>Leola R. Sudmann</u>	

(Licensed Embalmer's Statement on Reverse Side)

**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 Lester A. Witt

Licensed Embalmer No. 3254

P. O. Address Washington, D.C.

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.