MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

PARTMENT OF PUBLIC HEALTH AND WELFARE

-62-005305
STATE FILE NUMBER

AMENDED

Registration District No. 371 Primary Registration District No. 6262 Registrar's No. 2

FILED FEB 5 1962

1. PLACE OF DEATH
a. COUNTY: WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: W. DALLAS, TNP
Length of stay in 1b: 84 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION:
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: WEBSTER
c. CITY OR TOWN: ROGERSVILLE R3
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 8 MI N.E.
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First REUBEN Middle Last TRIPLETT
4. DATE OF DEATH: Month JAN Day 28 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5-28-1877
9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET FARMER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): MISSOURI
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: HAMILTON TRIPLETT
13b. MOTHER'S MAIDEN NAME: MARY JANE HAZEL
14. NAME OF HUSBAND OR WIFE:
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.: —
17. INFORMANT: THOMAS TRIPLETT Address: ROGERSVILLE,

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): Aortic Valvular Insufficiency
INTERVAL BETWEEN ONSET AND DEATH: 30 plus years.
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): Prostatitis - Chronic.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 1930, to Jan. 28, 1962 and last saw ~~her~~ him alive on Jan. 26, 1962
Death occurred at 9:15 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. P. Macdonnel (Degree or title) M.D.
22b. ADDRESS: Marshfield, Mo.
22c. DATE SIGNED: 1/29/62
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 1-31-1962
23c. NAME OF CEMETERY OR CREMATORY: MT OLIVE
23d. LOCATION (City, town, or county): WEBSTER Co (State) MO
24. FUNERAL DIRECTOR: BARBER-EDWARDS, MARSHFIELD. ADDRESS
25. DATE RECD. BY LOCAL REG.: FEB-1-1962
26. REGISTRAR'S SIGNATURE: Opal M. Good

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 George Staffe

Licensed Embalmer No. 3166

P. O. Address Mt. Sunset

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.