

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-009904
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 203

FILED APR 9 1962

VS 300
Rev. 4/59

2109
20100
3
4 0
5 0
6
7 0
8 2
99281
10 3
11 010
12 2-0
13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>20 days</u>	c. CITY OR TOWN <u>Hartsburg</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. of Mo. Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Keith William Sapp</u>			4. DATE OF DEATH Month Day Year <u>April 4, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-55</u>
9. AGE (last birthday) <u>6 years</u>		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) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Minor</u>	11. BIRTHPLACE (City and state & country) <u>Jefferson City, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>United States</u>		13a. FATHER'S NAME <u>Archille Sapp</u>	
13b. MOTHER'S MAIDEN NAME <u>Betty Anderson</u>		13c. NAME OF HUSBAND OR WIFE <u>None</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>Hospital Record - UMMC - Columbia, 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>Cardiac & Respiratory Arrest</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral edema, Contusion, Concussion</u>			<u>18 days</u>
DUE TO (c) <u>Kick by horse - Frontal Area</u>			<u>19 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonitis</u>			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 checked="" 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.) <u>Kicked in face by horse</u>	
20c. TIME OF INJURY Hour a.m. <u>11:30</u> Month, Day, Year <u>3 16 62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. CITY, TOWN, OR LOCATION <u>RT 1 Hartsburg</u>	COUNTY STATE <u>Boone Mo.</u>
21. I attended the deceased from <u>3-16-62</u> to <u>4-4-62</u> and last saw ^{him} alive on <u>4-4-62</u> Death occurred at <u>8:53</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>Henry J. Owen MD</u> (Degree or title)		22b. ADDRESS <u>UMMC - Columbia Mo.</u>	22c. DATE SIGNED <u>4-4-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>April 5, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Goshon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ashland Mo.</u>
24. FUNERAL DIRECTOR <u>Burnett Funeral Home</u>	ADDRESS <u>Ashland Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 5 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>

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 W^m L. Bennett

Licensed Embalmer No. 3564

P. O. Address Ashland Md

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.