

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14487

State File No. \_\_\_\_\_

Registrar's No. 121

Registration District No. 104

Primary Registration District No. 3008

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2 ✓  
(d) Length of stay: In hospital or institution 2 days (Specify whether) \_\_\_\_\_  
In this community 16 yrs.  
years, months or days)

3. (a) PRINT FULL NAME Oli Everett Sapp 100  
8. (b) If veteran, name war x 8. (c) Social Security No. x

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Naomi Sapp 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased Oct. 24<sup>th</sup> 1879  
(Month) (Day) (Year)

8. AGE: Years 60 Months 6 Days 4 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Boone County Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business x

MOTHER FATHER  
12. Name Burymann Sapp  
13. Birthplace Boone County Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Taratha Wilcox  
15. Birthplace Boone County Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature U. O. Sapp  
(b) Address Antwiler Mo

17. (a) Burial (b) Date thereof April 29 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Auxvasse, Antwiler

18. (a) Signature of funeral director Hughes Maupin  
(b) Address Auxvasse Mo

19. (a) April 29 1940 (b) R. H. Crews 101 1/2  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Callaway  
(c) City or town Auxvasse  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 28<sup>th</sup>  
year 1940 hour 8 minute 5 A.M.  
21. I hereby certify that I attended the deceased from 4/26/40  
\_\_\_\_\_, 19\_\_\_\_, to 4/28, 1940;  
that I last saw him alive on 4/28, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death acute perforation of gastric ulcer 4/26/40  
Duration \_\_\_\_\_

Due to chr. gastric ulcer

Due to \_\_\_\_\_

Other conditions Terminal Hypertensive Pneumonia 4/27/40  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations Perforation 1/2" indurated on lower curvature of stomach hi for pylorus  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Henry Drost (M. D. or other) M.D.  
Address 610 1/2 1st, Fulton, Mo Date signed 4/29/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 14 4 87

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
(a) County Callaway  
(b) City or town Jubla  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Callaway Hospital  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Th. E. Lapp  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year \_\_\_\_\_  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month Apr day 25-1940  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD!

MOTHER FATHER

S-1448D.