

Registration District No. **13**

Primary Registration District No. **3014**

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson City  
(c) Name of hospital or institution: St. Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Alice Updegraff

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 28 1859  
(Month) (Day) (Year)

8. AGE: 81 Years 4 Months 25 Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Franklin County, Penna. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Joseph Shirk

13. Birthplace Franklin Co. Penna. (City, town, or county) (State or foreign country)

14. Maiden name Sarah Arney

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

16. (a) Informant Mrs. Roy Cowley

(b) Address 304 Bolivar

17. (a) Burial (b) Date thereof 2-25-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Overview

18. (a) Signature of funeral director James Service

(b) Address 700 Jefferson

19. (a) 2-24-41 (b) D. W. Bedford, W. C.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole  
(c) City or town Jefferson City (If outside city or town limits, write "RURAL")  
(d) Street No. 1000 Poplar (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23 year 1941 hour 8 minute P M.

21. I hereby certify that I attended the deceased from Jan 15, 1941, to Feb 23, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Decomposed heart

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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 J. G. Bruce (M. D. or other) W. C.  
Address Jefferson City Date signed 2/24/41

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

40-40

7-30  
7-39  
X23159

FILED MAR 14 1941 13

**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  
..... Registered Apprentice No. ....  
working under my personal supervision.

Signed *L. H. Anderson*

Licensed Embalmer No. *3641*

P. O. Address *Jefferson City, Mo.*

**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 this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 67253

Registration District No. 213

Primary Registration District No. 2014

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Cole  
(b) City or town Jefferson City  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Alice Updegraff

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Samuel Updegraff 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 25 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

19. (a) 2/24/41 (b) Samuel M.D. (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 23 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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 G. Bruce (M. D. or other) \_\_\_\_\_  
Address Jefferson City Date signed \_\_\_\_\_

SUPPLEMENTAL

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

MOTHER FATHER

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

