

No. 2
4-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3233

FILED FEB 15 1946

Registration District No. 18

Primary Registration District No. 3040

State File No.

Registrar's No. 175

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
219 Calhoun St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether)

In this community 50 yrs.
years, months or days

3. (a) PRINT FULL NAME Frances Anna Rupp

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Peter Joseph Rupp

6. (c) Age of husband or wife if alive years

7. Birth date of deceased January 22, 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 7
If less than one day hr. min.

9. Birthplace Quincy Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name John Koch

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

14. Maiden name Anna Albrecht

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

16. (a) Informant Paul Rupp

(b) Address Chillicothe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45
(Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director Donald F. Gordatz

(b) Address Chillicothe Missouri

19. (a) Jan-4-1946 (b) Francis B. Neill
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")

(d) Street No. 219 Calhoun St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan. day 1
year 1946 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec 31, 1945 to 1/1/46
that I last saw h. ex alive on 12/31/45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

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 (M. D. or other).....
Address Chillicothe MO Date signed 1-3-46

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

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DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Donald F. Gordon*

Licensed Embalmer No. *4191*

P. O. Address..... *Chillicothe, 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.