

FILED JAN 13 1947

Registration District No. 3

Primary Registration District No. 5030

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

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

1. PLACE OF DEATH:  
 (a) County Atchison  
 (b) City or town Rural, Tarkio Twsp.  
(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)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Atchison  
 (c) City or town Rural, Tarkio Twsp.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

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

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 12 day 11  
 year 1946 hour 7:30 minute P.M. M.

4. Sex Female 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: 2 13 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 1, 1946  
 \_\_\_\_\_, 19\_\_\_\_, to Dec. 11, 1946;  
 that I last saw her alive on Dec. 11, 1946;  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
87 9 28 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death cerebral hemorrhage  
 Due to Arteriosclerosis and Hypertension  
 Due to \_\_\_\_\_

9. Birthplace Lafayette Co., Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housekeeper

Other conditions none  
(Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name Thomas Ward  
 13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Margaret Rupe  
 (b) Address Rock Port, Mo.  
 17. (a) Burial (b) Date thereof 12-13-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Englishgroove  
 18. (a) Signature of funeral director Baetholomew Mark  
 (b) Address Rock Port, Mo.  
 19. (a) 12-13-46 (b) Betty Crutcher  
(Date received local registrar) (Registrar's signature)

23. Signature Thomas A. Riddle (M. D. or other)  
 Address Rock Port, Mo. Date signed Dec 12, 1946

Duration  
3 days  
10 yrs.  
 PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

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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 Gray Barchaloum  
Licensed Embalmer No. 3173  
P. O. Address Rock Port, 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.