

FILED AUG 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26034

BIRTH NO. _____ REG. DIST. NO. 34 PRIMARY REG. DIST. NO. 5117 Registrar's No. 13

0100

1. PLACE OF DEATH a. COUNTY Boona		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Cedar		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Cedar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hartsburg R.F.D.		d. STREET ADDRESS (If rural, give location) Hartsburg R.F.D.	
3. NAME OF DECEASED (Type or Print) Lewis H Sapp		4. DATE OF DEATH July 18 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-18-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE (In years last birthday) 73 3 4
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John H. Sapp		13b. MOTHER'S MAIDEN NAME Nancy Perkins	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME LARRY SAPP	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Diabetes mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 5-11, 1950, to July 17, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE LeRoy J. Miller M.D.		23b. ADDRESS Ashland Mo	
23c. DATE SIGNED 7-20-50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 7-20-1950		24c. NAME OF CEMETERY OR CREMATORY Goshen Cem	
24d. LOCATION (City, town, or county) (State) Ashland Rural Mo		25. FUNERAL DIRECTOR'S SIGNATURE W.C. Burnett	
25. ADDRESS Ashland Mo		DATE REC'D BY LOCAL REG. 7-20-50	
REGISTRAR'S SIGNATURE Mrs. Mildred Burnett		27	

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED ⁸⁻¹⁶⁻⁵⁰
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 8-16-50

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 _____
Student Embalmer

Signed _____

W. C. Bennett

Licensed Embalmer No. _____

P. O. Address _____

*3564
Rockland, 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.