

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30014**
803

FILED SEP 24 1951

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 803

0396

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2316 N. BOONVILLE		d. STREET ADDRESS (If rural, give location) 2316 N. BOONVILLE	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) DAVID c. (Last) SAPP			4. DATE OF DEATH (Month) (Day) (Year) SEPT. 17 1951
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT. 5 1903
9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR	11. BIRTHPLACE (State or foreign country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME JAMES SAPP	13b. MOTHER'S MAIDEN NAME NANCY MALLOCK
14. NAME OF HUSBAND OR WIFE JESSE SAPP		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME MRS. JESSE SAPP		ADDRESS SPRINGFIELD	
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, asthma, etc. It means the disease, injury, or complication which caused death.			INTERVAL BETWEEN ONSET AND DEATH 5 min.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 checked="" 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)	4201
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 <u>9-17-51</u> , 19 <u>51</u> , to <u>9-17-</u> , 19 <u>51</u> ; that I last saw the deceased alive on <u>9-17-</u> , 19 <u>51</u> , and that death occurred at <u>12:45</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Paul O. Monte M.D.		23b. ADDRESS 1630 N. Jefferson	23c. DATE SIGNED 9-18-51
24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	24b. DATE SEPT. 20-51	24c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL	24d. LOCATION (City, town, or county) (State) WEST OF SPRINGFIELD, MO
DATE REC'D BY LOCAL REG. 9-19-51	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. Klingner & Co. Springfield	

M.B.

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

Max Rhodes
Licensed Embalmer No. 4071
P. O. Address Springfield

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.