

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17732

State File No.

FILED JUN 20 1955

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 150

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Columbia</u>	c. LENGTH OF STAY (in this place) <u>16 hrs</u>	c. CITY OR TOWN <u>Ashland</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		STREET ADDRESS (If rural, give location) <u>0100th</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Gay</u> b. (Middle) <u>S</u> c. (Last) <u>Sapp</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 11 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 1 1875</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, season if regular) <u>Farmer Riter</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Sapp</u>	13b. MOTHER'S MAIDEN NAME <u>Paralea Sapp</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Jessie Crane</u> ADDRESS <u>Ashland Mo</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Thrombosis</u>		
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"/>
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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) <u>331X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-18, 1955 to 6-11, 1955, that I last saw the deceased alive on 6-10, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>R.P. Ladewig M.D.</u> (Degree or title)	23b. ADDRESS <u>Columbia Mo</u>	23c. DATE SIGNED <u>6-11-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 13 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Salem Cemt</u>	24d. LOCATION (City, town, or county) (State) <u>Ashland Mo</u>
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DATE REC'D BY LOCAL REG. <u>June 13 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	31	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Burnett</u> ADDRESS <u>Ashland Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *W. L. Burnett*

Licensed Embalmer No. *35*

P. O. Address *Ashland*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.