

FILED DEC 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41303

State File No.

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 157

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		c. LENGTH OF STAY (in this place) <u>4 1/2 yrs.</u>	c. CITY OR TOWN <u>Lock Springs</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1521 Clay St.</u>		e. STREET ADDRESS (If rural, give location) <u>No street address</u> <u>0540</u>	

3. NAME OF DECEASED (Type or Print) <u>John Harvey Rupe</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 8, 1955</u>
--	------------	-------------	-----------	--

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>Apr. 5, 1863</u>	9. AGE (In years last birthday) <u>92</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	--	---	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>West Liberty, Ky.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	--	--

13a. FATHER'S NAME <u>William Rupe</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Carroll</u>	14. NAME OF HUSBAND OR WIFE <u>Lou Emma (dec)</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>IX</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Rupe, Henderson, Iowa</u>	ADDRESS
---	--	---	---------

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</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>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331x</u>			

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)
--	--	---

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 Dec 7, 1955, to Dec 7, 1955, that I last saw the deceased alive on Dec 7, 1955, and that death occurred at 2:15A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William L. Fair, M.D.</u>	23b. ADDRESS <u>Chillicothe, MO</u>	23c. DATE SIGNED <u>12-9-55</u>
--	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Dec. 10, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lock Springs cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Lock Springs, Mo.</u>
--	-----------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>12-9-55</u>	REGISTRAR'S SIGNATURE <u>Francis B. Hill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alvord Gordon</u>	ADDRESS <u>Chillicothe, MO.</u>
--	---	--	------------------------------------

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 *Richard H. Bandall*

Licensed Embalmer No. *48*

P. O. Address *Phillip*

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.