

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26181

XC-45 84 58 FILED AUG 31 1956  
REG.# 12235

43  
Registration District No. Primary Registration District No. 3007 Registrar's No. 438

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>TEXAS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>POPLAR BLUFF</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>SUMMERSVILLE</b> 1070 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b> <b>18 DAYS</b>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> <b>GENERAL DELIVERY</b>	

3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>(NMI)</b> Last <b>VANPELT</b>			4. DATE OF DEATH <b>AUGUST 17, 1956</b> Month Day Year		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 19, 1895</b>	9. AGE (In years last birthday) <b>61</b>	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) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRI CULTURE</b>	11. BIRTHPLACE (City and state or country) <b>LEAVENWORTH, KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>NEWTON WOOD VANPELT</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET ANN WIMER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED PERITONITIS, SECONDARY TO PERFORATED APPENDIX.</b> Interval between ONSET AND DEATH <b>23 DAYS</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PARTIAL <b>SMALL BOWEL OBSTRUCTION, SECONDARY TO PERFORATED APPENDIX.</b> DUE TO (b) Interval between ONSET AND DEATH <b>23 DAYS</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5501</b>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour Month; Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **July 30, 1956** to **August 17, 1956**  
Death occurred at **10:23A.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Printer or title) <b>ERNEST H. TAPP, M.D., Chief Professional Svcs. VA Hospital, Poplar Bluff, Mo.</b>	22b. ADDRESS	22c. DATE SIGNED <b>8-17-56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-17-56</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>HOUSTON MO</b>
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24. FUNERAL DIRECTOR ADDRESS <b>ELLIOTT Funeral Home, HOUSTON MO</b>	25. DATE RECD. BY LOCAL REG. <b>8/27/56</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

89-0

RECEIVED  
AUG 27 1956

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

SEP 14 1956

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 *Walter N. Fitch*

Licensed Embalmer No. *385*

P. O. Address *Regina, Ill.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.