

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**37083**

STATE FILE NUMBER

FILED OCT 18 1957

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 321

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Farmington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Farmington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b	d. STREET ADDRESS <b>39 Pine</b>			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Wilfred Allison Sapp</b>				4. DATE OF DEATH <b>October 10, 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1890</b>		9. AGE (In years last birthday) <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Trimfoot Co.</b>		11. BIRTHPLACE (City and state or country) <b>Boone County, Missouri</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Boone Sapp</b>				14. MOTHER'S MAIDEN NAME <b>Emma Reppo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. W. I</b>		16. SOCIAL SECURITY NO. <b>490-07-1336</b>		17. INFORMANT <b>Mrs. Earnestine Sapp Farmington, Missouri</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>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>glass</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis, generalized</b>						
	DUE TO (c) <b>4200</b>						
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis, Chronic Bronchitis</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 <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 <b>Feb 1956</b> to <b>Oct 10, 1957</b> and last saw <del>the</del> <b>him</b> alive on <b>Oct. 9, 1957</b> Death occurred at <b>11 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert A. Huckstep M.D.</b>				22b. ADDRESS <b>Farmington, Mo.</b>		22c. DATE SIGNED <b>10-10-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/12/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Columbia, Missouri</b>		
24. FUNERAL DIRECTOR <b>Miller Funeral Home Farmington, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Oct. 10, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>		

OCT 18 1957

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 Robert K. Dergal

Licensed Embalmer No. 4129

P. O. Address Farmington

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