

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010648

STATE FILE NUMBER

Health,  
& Welfare  
Public  
Service

FILED MAR 17 1959

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 94

S. 300  
1-57 2

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>New Wells</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 4</u>		Length of stay in lb <u>56Yr- 6 Days</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>J.</u> Last <u>SCHUPPAN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1877</u>		9. AGE (In years last birthday) <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Louis Schuppan</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Lehner</u>		14. NAME OF HUSBAND OR WIFE <u>-</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>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Records State Hospital #4-Farmington, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of Right Femoral Artery</u>					INTERVAL BETWEEN ONSET AND DEATH <u>40 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>					unknown
DUE TO (c) <u>Psychosis</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>None</u>			
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.) <u>None</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>8-15-53 at intervals 3-3-59</u> and last saw <sup>her</sup> alive on <u>3-3-59</u> Death occurred at <u>State Hospital # 4 - 12:30AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John A. Brennan M.D.</u>			22b. ADDRESS <u>State Hospital # 4-Farmington, Mo</u>		22c. DATE SIGNED <u>3-3-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Wells</u>		23d. LOCATION (City, town, or country) (State) <u>New Wells, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>McCombs - 417 N. High, Jackson, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Mar. 9, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *B. Meyer* .....

- Licensed Embalmer No. *3051* .....

P. O. Address *Jackson* .....

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.