

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018304

STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. 172 Primary Registration District No. 4272 Registrar's No. 43

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Waverly</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waverly</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Malta Bend</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kelling Clinic</u>		Length of stay in lb <u>1 wk.</u>	d. STREET ADDRESS <u>0970</u> (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL W. TAPSCOTT</u>			4. DATE OF DEATH Month Day Year <u>May 23 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9 1871</u>	9. AGE (In years last birthday) Months Days Hours Min. <u>87</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Labell Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Tapscott</u>			
13b. MOTHER'S MAIDEN NAME <u>Mary Sanders</u>		14. NAME OF HUSBAND OR WIFE <u>Floral Hills Cem., K.C. Mo.</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.		17. INFORMANT <u>Floral Hills Cem., K.C. 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>Carcinoma metastatic of lungs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Do not know</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>					<u>Do not know</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>165XF</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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>While standing up fell backwards and fell to floor, hitting a foot stool. Fracture of upper third, left femur.</u>			
20c. TIME OF INJURY Hour Month, Day, Year <u>5-18-59</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Kelling Clinic & Hosp.</u>		20f. CITY, TOWN, OR LOCATION <u>Waverly</u>		COUNTY STATE <u>Lafayette Missouri</u>	
21. I attended the deceased from <u>May 16, 1959</u> to <u>May 23, 1959</u> and last saw her/him alive on <u>May 23, 1959</u> Death occurred at <u>1:55 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Geo A. Kelling M.D.</u>			22b. ADDRESS <u>Waverly, Missouri</u>		22c. DATE SIGNED <u>5-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
24. FUNERAL DIRECTOR <u>Barley-Hobson, Waverly Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>May 25-59</u>		26. REGISTRAR'S SIGNATURE <u>Lutie Gordon Jordan</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 *Ben W. Gibson*

Licensed Embalmer No. *2961*
P. O. Address *Carrollton*

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.