

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024406

FILED VS AUG 4 1959 53

3010

266

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|--|---------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Cape Girardeau | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau | Length of stay in 1b 2 Days | c. CITY OR TOWN Jackson | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Southeast Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) 319 Morgan |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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| 3. NAME OF DECEASED (Type or print) First Cindy Middle Kay Last Saupe | | | 4. DATE OF DEATH Month July Day 23 Year 1959 | |
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|-----------------|---------------------------|---|------------------------------------|--|
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/22/59 | 9. AGE (last birthday) IF UNDER 1 YEAR: Months _____ Days 1 IF UNDER 24 HR: Days 18 Hours 30 min. |
|-----------------|---------------------------|---|------------------------------------|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Cape Girardeau | 12. CITIZEN OF WHAT COUNTRY U. S |
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| 13a. FATHER'S NAME Earl Saupe | 13b. MOTHER'S MAIDEN NAME Marlene Bodenschetz | 14. NAME OF HUSBAND OR WIFE none |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Earl Saupe Jackson MO | Address _____ |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interventricular Septal Defect | | INTERVAL BETWEEN ONSET AND DEATH 2 days. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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|---|------------------------|
| 20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____ | Month, Day, Year _____ |
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|--|--|--|--------------|-------------|
| 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 Jackson | COUNTY _____ | STATE _____ |
|--|--|--|--------------|-------------|

21. I attended the deceased from **7-22-59** to **7-23-59** and last saw her ^{him} alive on **7-23-59**
Death occurred at **7:45** ^Pm on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE J. M. Jagger, MD McCombs Funeral Home | 22b. ADDRESS Jackson Mo | 22c. DATE SIGNED 7-24-59 |
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|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7/24/59 | 23c. NAME OF CEMETERY OR CREMATORY Zion | 23d. LOCATION (City, town, or county) (State) Pocahontas Mo |
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| 24. FUNERAL DIRECTOR McCombs | ADDRESS Jackson Mo | 25. DATE RECD. BY LOCAL REG. 7-25-1959 | 26. REGISTRAR'S SIGNATURE Dune Koster |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B A Meyer

Licensed Embalmer No. 3057

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.