MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

23174

File No.
Registered No. 6636

1. PLACE OF DEATH
County
Registration District No. 791
Township
Primary Registration District No.
City St Louis (No. ISOLATION HOSPITAL St. Ward)

2. FULL NAME Richard Cuppett
(a) Residence. No. 2624 Lafayette St. 23 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-23-1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.
	2	2	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Edward Cuppett
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Maryland
12. MAIDEN NAME OF MOTHER Lilla Byington
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

14. INFORMANT Leona Burns
(Address) ISOLATION HOSPITAL

15. FILED [illegible] 1931 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-16 1931

17. I HEREBY CERTIFY, That I attended deceased from 6-14, 1931, to 6-16, 1931 that I last saw him alive on 6-16, 1931 and that death occurred, on the date stated above, at 10:35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Meningitis #32
24A (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) 24 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? by Clinical
(Signed) L. F. Kempare, M. D.
, 19 (Address) ISOLATION HOSPITAL

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bonne Terre Mo.	6-18 1931
20. UNDERTAKER	ADDRESS
McLaughlin	1631 Mo. ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.