

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27223
Registrar's No. 27

Registration District No. 99

Primary Registration District No. 4172

1. PLACE OF DEATH:

(a) County De Kalb
(b) City or town Stewartsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME John Piepergerdes

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 29 1967
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Westerlo Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Eliert Piepergerdes U
13. Birthplace Westerlo Germany
(City, town, or county) (State or foreign country)
14. Maiden name Anna Schroeder
15. Birthplace Westerlo Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. L. Simpson
(b) Address R. F. D. 1 Stewartsville Mo
17. (a) Burial (b) Date thereof Aug 11 47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director F. J. ...
(b) Address Stewartsville Mo
19. (a) 8-15-47 (b) R. D. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Kalb
(c) City or town Stewartsville, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1947 hour 16 minute 35 P. M.

21. I hereby certify that I attended the deceased from 7-17, 1947 to 8-8-47, 1947;
that I last saw him alive on 8-7-1947, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia hypostatic Duration 3 days

Due to Heart Disease Arterio-sclerotic, Aortic insufficiency 1 year
Due to Arteriosclerosis, General 1 year

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 97 B
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature N. C. ... (M. D. or other)
Address 207 N. S. St. Joseph, Mo Date signed 8-9-47

WHILE PLAINLY USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1 X 1081

HEALTH OFFICE
Cameron, Mo.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. G. Brown

Licensed Embalmer No. *952-*

P. O. Address. *Stewartville*

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 this body is not embalmed, above space should be left blank.