

MAY 25 1927

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

Do not use this space.
Mr. Miller
10869

1. PLACE OF DEATH
County *Subsain* Registration District No. *26*
Township *Halltown* Primary Registration District No. *5034*
City *Neuro de R. F. D.* (No.) St. Ward (....)

2. FULL NAME *John Thomas Seepes*
(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No.
Registered No. *42*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 11 - 1889*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 6 29

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 10 1927*
17. I HEREBY CERTIFY That I attended deceased from *April 8*, 1927, to *April 10*, 1927 that I last saw him alive on *April 10*, 1927, and that death occurred, on the date stated above, at *8 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS
Cerebral Hemorrhage

824
7401

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Calloway Co., Mo.*

10. NAME OF FATHER *Arthur Seepes*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER, *Henderson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

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

(Signed) *Ernie Miller*, M. D.
1029 (Address) *Mexico Mo.*

*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.

14. INFORMANT *was John T. Seepes*
(Address) *Mexico Mo. R. F. D. 48*

15. *April 11th 1927* *Ira S. Milligan*
FILED (Date) (Time) REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *McPheters Bros* DATE OF BURIAL *Apr 12th 1927*

20. UNDERTAKER *McPheters Bros* ADDRESS *Mexico Mo*

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.

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

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1. PLACE OF DEATH

County Judicial
Township Salt River
City..... (No.....)

Registration District No. 26
Primary Registration District No. 5034

File No.....
Registered No. 420
St..... Ward.....

2. FULL NAME

John Phos. Leeper

(a) Residence, No..... St.,..... Ward.....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. da.
(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)

10. NAME OF FATHER Arthur Leeper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Ann Henderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT (Address)

15. April 11, 1927 Ira S. Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 10 1927

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*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

20. UNDERTAKER ADDRESS

19

SUPPLEMENTAL

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.

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