

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

Do not use this space.  
**32017**

**1. PLACE OF DEATH**  
 County.....  
 Township.....  
 City.....  
 Registration District No. **791**  
 Primary Registration District No. **1003**  
 (No. **Mo. Pac. Road**)  
 St. .... Ward .....

**2. FULL NAME** *Charles Marian Laipple*  
 (a) Residence. No. ....  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. **42** ds. How long in U.S., if of foreign birth? yrs. mos. ds.  
 Ward. *17* **Sedalia Mo.**  
 (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** *Male* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Married*  
 (write the word)  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** *Mrs C M Laipple*  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *05-28-1875*  
**7. AGE**  
 YEARS MONTHS DAYS IF LESS than I day, hrs. or min.  
*53 6 20*

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work *Crook Carpenter*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *Railroad*  
 (c) Name of employer *Mo Pac R.R.*

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

**10. NAME OF FATHER**  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)**  
**12. MAIDEN NAME OF MOTHER**  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)**

**14. INFORMANT** *Wife C. M. Laipple*  
 (Address) *Sedalia - Mo.*

**15. FILED** *May 27 1928*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *9/17/28* 19 *28*  
**17.**  
 I HEREBY CERTIFY, That I attended deceased from *Aug 6*, 19*28*, to *Sept 17*, 19*28*.  
 that I last saw *him* alive on *Sept 17*, 19*28*, and that death occurred, on the date stated above, at *2:15 a. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*1) Hypertension*  
*2) Myocarditis, Chronic*  
 (duration) yrs. mos. ds.  
*13 1 1*

CONTRIBUTORY (SECONDARY) *Hypertension, Chronic Paralyzing Arterio Sclerosis*  
 (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? *Clinical Observation*  
 (Signed) *Jerome S. Leary*, M. D.  
*9/17/1928* (Address) *Mo Pac Road*

\*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** *Sedalia - Mo.* **DATE OF BURIAL** *Sep 19 1928*

**20. UNDERTAKER** *Edw. F. Amundson*  
 ADDRESS *1212 St. Louis Ave*

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 791 File No. ....  
Township St. Louis Primary Registration District No. 1103 Registered No. 9278  
City St. Louis (No. Mo. Reg. Dist.) St. .... Ward)

**2. FULL NAME** Charles Marian Laipple

(a) Residence. No. .... St. 7 Ward. Leclaire Mo  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. 42 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (or) WIFE X  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28 - 1885  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min. 43 X 6 2 19

**8. OCCUPATION OF DECEASED**

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

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**14.**

INFORMANT  
(Address)

**15.**

FILED SEP 25 1928 Max E. Stankov  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1928

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.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

**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**

19

**20. UNDERTAKER**

**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY



ADDRESS ALL COMMUNICATIONS  
TO THE STATE BOARD OF HEALTH

THE STATE BOARD OF HEALTH  
OF MISSOURI  
CITY OF JEFFERSON

JAMES STEWART, M. D., SECRETARY  
AND STATE HEALTH COMMISSIONER  
IRL BROWN KRAUSE, M. D., ASSISTANT  
HEALTH COMMISSIONER

Oct. 30, 1928.

In Re: Death certificate of  
Charles Marian Laipple,

McLaughlin Bros, Furn.Co.  
5136517 Ohio St.,  
Sedalia, Mo.

Dear Sir:-

In regard to the death certificate for the above named, will say, that the certified copy which we sent you was the copy of the original certificate we have in our files. Enclosed is a supplemental kindly fill in the age and date of birth. Send this supplemental to Dr. Max C. Starkloff, Municipal Courts Bldg. St. Louis, Mo. he will sign and forward same to this office. However, if you desire a corrected copy you will have to forward us the fee of fifty cents for a new certificate.

Very respectfully,

*James Stewart, M.D.*  
James Stewart, M.D.  
State Registrar.

G.

JNO. C. MCLAUGHLIN, PRESIDENT

ESTABLISHED 1880

A. M. MCLAUGHLIN, VICE PRESIDENT

# MCLAUGHLIN BROS. FURNITURE CO.

FUNERAL DIRECTORS

513-517 OHIO STREET

SEDALIA, MO.

October 24th  
19 28

Dr. Max C. Starkloff,  
St. Louis, Mo.

Dear Doctor:

Enclosed find letter with supplementary which is self-explanatory. Will you kindly fill out same and mail to Dr. Stewart at Jefferson City?

Thanking you, we are

Yours truly,  
MCLAUGHLIN BROS. FURN. CO.