

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

Do not use this space.

32502

1. PLACE OF DEATH

County Juniata
Township Juniata
City..... (Name).....

Registration District No. 849 ✓
Primary Registration District No. 6175

File No.....
Registered No. 6
St..... Ward.....

2. FULL NAME

Andrea M. Jepson

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17, 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 | 0 | 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Doit. Ruess

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Doit. Ruess

12. MAIDEN NAME OF MOTHER Doit. Ruess

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Denmark

14. INFORMANT Jessie Jepson
(Address) Green Castle, Mo

15. FILED Sept. 11, 1928 Miss Kate Lane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-6 19 28

17. I HEREBY CERTIFY, That I attended deceased from his home, 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 9/6-28-3 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Organic Heart disease
died suddenly
92A ✓

(duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY..... No

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. M. Parsons, M. D.

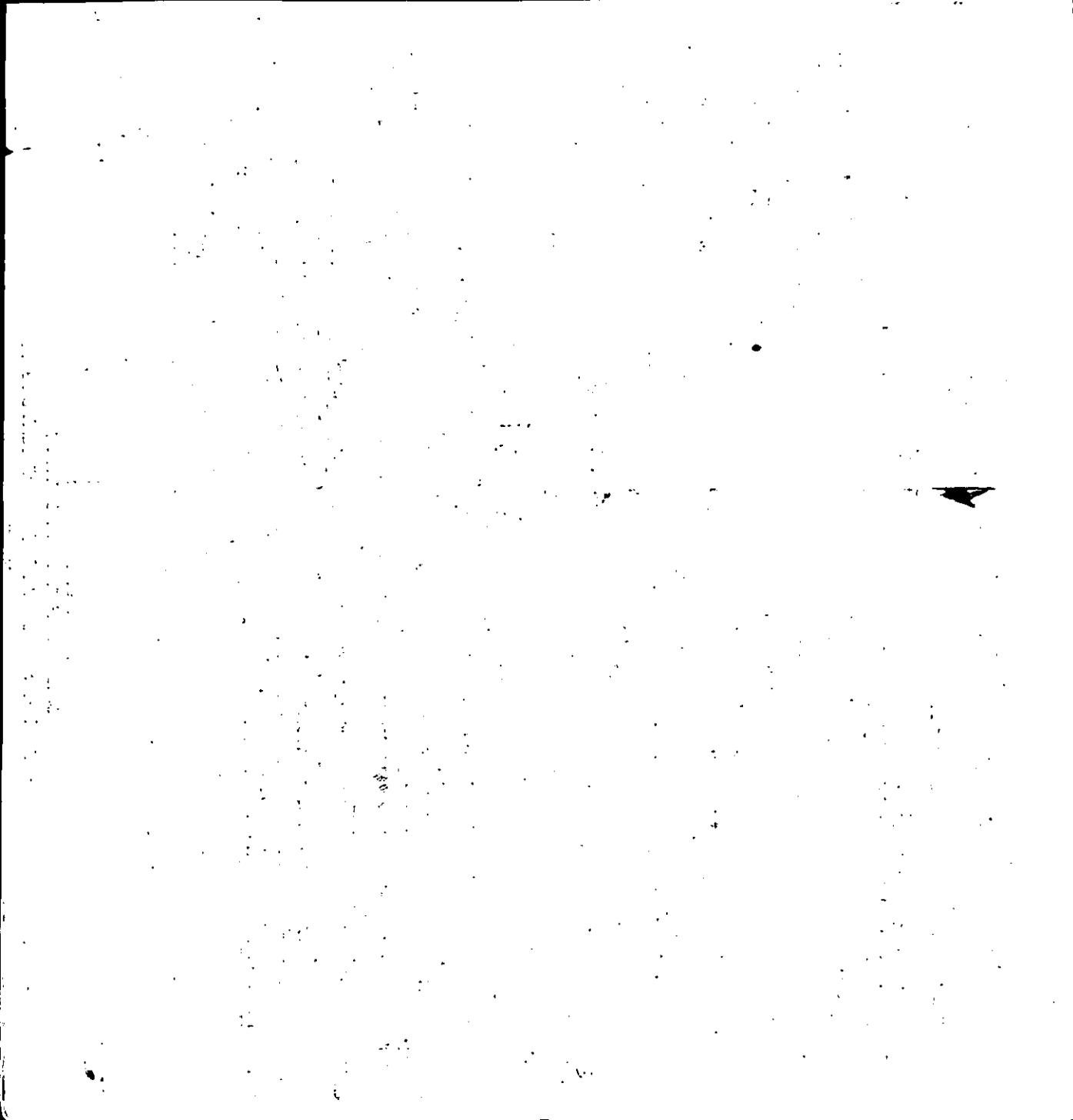
9/17, 1928 (Address) Green Castle Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Hannah Lane, 9/8 19 28

20. UNDERTAKER Gleason E. Kent ADDRESS Green City, Mo



**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.....*Sullivan*..... Registration District No.....*849*..... File No.....
Township.....*Union*..... Primary Registration District No.....*615*..... Registered No.....*6*.....
City..... (No.....)..... St..... Ward.....

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *♀* 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) *aug 17 - 1861*

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
(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 11 28* *Miss Kate Lane* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 6 1928*

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., 19....., and 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:

*Acute Heart Disease
of Sudden Valvular*
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *9000*
(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

20. UNDERTAKER ADDRESS

HALL NOT RECEIVE A FILE FOR CERTIFICATE UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW



S-22502