

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

Do not use this space.

11271

1. PLACE OF DEATH

County..... *Jeff.* Registration District No. *423*
 Township..... *Rock* Primary Registration District No. *5578*
 City..... (No.) St. Ward)

File No. *14*
 Registered No.

2. FULL NAME

Susanna Kiphaert
 (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.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. LE-MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF *John Kiphaert*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 23-1859*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
69 8 21

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Nashville Ind.*
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Alexander Jones*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Columbus Ind.*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mary Keane*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Richmond Ind.*
 (STATE OR COUNTRY)

14. INFORMANT *William Taylor*
 (Address) *Kimmswick Mo.*

15. FILED *3/18*, 19*29* *H. M. Eld*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 16 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Several months ago*, 19*29*, to *March 16*, 19*29* that I last saw her alive on *March 16*, 19*29*, and that death occurred, on the date stated above, at *5-50 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio Sclerosis

107A
97

CONTRIBUTORY *Broncho pneumonia*
 (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED *Ind.*

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Dr. J. Kine*, M. D.

3/18, 19*29* (Address) *Kimmswick 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 *Concordia Cemetery* DATE OF BURIAL *March 19 1929*

20. UNDERTAKER *Dr. H. Heiligtag* ADDRESS *Kimmswick Mo. Ind.*

WRITE PLAINLY, WITH UNFADING INK. THIS IS A

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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65
1929

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2
2

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