

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

20796

1. PLACE OF DEATH
 (County) Buchanan Registration District No. 85
 Township St Joseph Mo Primary Registration District No. 1001
 City St Joseph Mo (No. 3229 Lafayette) St. _____ Ward _____
 2. FULL NAME John Kiepitt
 (a) Residence. No. 3229 Lafayette 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 Male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 25, 1851

7. AGE YEARS 78 MONTHS 0 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Germany

10. NAME OF FATHER John Kiepitt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Kay Porter
 (Address) 3229 Lafayette

15. FILED 1-1929 19 _____ REGISTRAR John P. St

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29, 1929

I HEREBY CERTIFY That I attended deceased from _____, 1929, to _____, 1929
 that I last saw him alive on June 29, 1929, and that death occurred, on the date stated above, at 10:30 P.M.

THE CAUSE OF DEATH* was as follows:
Chronic Coronary Atherosclerosis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Myocardial Infarction
 (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) W. Schmidt, M.D.
 (Address) St Joseph 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 Mt Auburn DATE OF BURIAL July 1, 1929

20. UNDERTAKER Sheehan Funeral Home ADDRESS 1946 Colburn

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. WHITE PAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

25 1929
 262
 10
 10
 10

