

REG'D SEP 14 1939
Registration District No. 157

Primary Registration District No. 3036

Registrar's No. 131

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
813 N. Second Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Elizabeth Heppermann 165
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Female race White
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Henry Heppermann
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 7 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 6 23 _____ hr. _____ min.

9. Birthplace Monticello Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 0

11. Industry or business At Home 5

12. Name Robert Spain 5

13. Birthplace Princeton
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Reed

15. Birthplace Princeton
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Isabella Kuschalt

(b) Address St. Charles, Mo

17. (a) Burial (b) Date thereof Sept. 1-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Hill Cemetery

18. (a) Signature of funeral director A. C. Ballinger, Jr.

(b) Address St. Charles, Mo

19. (a) 8/21/39 (b) Lawrence H. Kessler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 1
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 813 N. Second St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30
year 1939 hour 9 minute 4 M.

21. I hereby certify that I attended the deceased from February 5
1929, to August 30, 1939;
that I last saw her alive on August 30, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Pulmonary hemorrhage 2 hr
Due to hypertension & arteriosclerosis 5 yrs?

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature George E. Kuter (M. D. or other) MD
Address St. Charles, Mo Date signed 9/1/39

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.

23

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30065-

Do not use this space.

1. PLACE OF DEATH
(a) County St Charles Registration District No. 757
(b) Township St Charles Primary Registration District No. 3036 Registered No. 131
(c) City St Charles (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Heppermann
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 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. 71 6 23

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

FATHER
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____
19. FUNERAL DIRECTOR (ADDRESS) _____
20. FILED _____ 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-30-1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Pulmonary Hemorrhage
Hypertension + arteriosclerosis
Atherosclerosis - atherosclerosis of branches
Other contributory causes of importance: _____

Date of onset _____

Name of operation _____ 73 _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Geo. E. Kester, M. D.
(Address) St Charles, Mo.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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(b) Township St Charles Primary Registration District No. 3026 Registered No. 131
(c) City St Charles (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Elizabeth Hippermann
- (a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE 10 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)
- 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.
71 6 23
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
- FATHER 13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TRUXTON MISSOURI
- MOTHER 15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TRUXTON MISSOURI
17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____
19. FUNERAL DIRECTOR (ADDRESS) _____
20. FILED Nov 30 1939 Glorious B. Measer Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-30, 1939

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Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
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Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) G. E. Kestner, M. D.
(Address) St Charles

CAUSE OF DEATH in plain terms, so that it m

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

IF SUCH MAN SHOULD HAVE
"AT ON IS VERY IMPORTANT