

FILED APR 19 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

961

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days) 1 1/2

3. (a) PRINT FULL NAME Marie Reppner
8. (b) If veteran, name war ✓
3. (c) Social Security No. 150

4. Sex male 5. Color or race w
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mr. J. Reppner
6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased Mar 14 - 1908
(Month) (Day) (Year)

8. AGE: Years 34 Months 3 Days 15
If less than one day hr. min.

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business

12. Name Thomas Reppner

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

14. Maiden name Reppner

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

16. (a) Informant's own signature George Reppner

(b) Address 2170 S. Montchal

17. (a) Burial (b) Date thereof Mar 2 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director James Reppner

(b) Address Mch 1, 1940

19. (a) Mch 1, 1940 (b) M.M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kennett - City
(If outside city or town limits, write "RURAL")
(d) Street No. 1203 Montchal
(If rural, give location)
(e) If foreign born, how long in U. S. A. 1 1/2 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 29 day 29
year 1940 hour 7:30 minute 30 A.M.

21. I hereby certify that I attended the deceased from 11-28-39
2/29, 1940 to 2/29, 1940
that I last saw her alive on 2/28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis of 3 months
duration
spine and feet etc.
Due to 194

Due to interstitial nephritis
Other conditions acute (n.m.o)
(Include pregnancy within 3 months of death)

Major findings:
Of operations no
Of autopsy no

PHYSICIAN

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? no

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature D.P. Russell (M. D. or other) _____
Address 2231 E. 11th Date signed _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

50M-5-17-39
Rev. 5-17-39
1 X1951

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.....

Harry Lauron - Apprentice, Registered Apprentice No.....
working under my personal supervision.

Signed *John B. Camp*
Licensed Embalmer No. *2955*
P. O. Address *170 9th*

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 95-27
Registrar's No. 961

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 999

Primary Registration District No. 1002

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town X. E.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Marie Heffner

3. (b) If veteran, name war Wavie 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased Nov 14 1904
(Month) (Day) (Year)

8. AGE: Years 35 Months 3 Days 15 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/1/40 (b) M. H. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 29
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 D. P. Russell (M. D. or other) _____

Address 3231 E 11 St Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940
5-9527