

STANDARD CERTIFICATE OF DEATH

State File No. **3460**

1 X23159

FILED FEB 19 1941

Registration District No. 516 Primary Registration District No. 5764 Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Mississippi County
 (b) City or town Bertrand
 (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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mississippi County, State of Mo.
 (b) City or town Bertrand, Mo.
 (If outside city or town limits, write "RURAL")
 (c) Street No. _____ (If rural, give location)
 (d) If foreign born, how long in U. S. A.? 0 years

3. (a) PRINT FULL NAME Etta Bell Lepley
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 23
 year 1941 hour 6 minute P.M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife Mr. Lepley 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased: 12 (Month) 14 (Day) 1869 (Year)

that I last saw her alive on Sunday - Jan 12, 1941; and that death occurred on the date and hour stated above.
 Immediate cause of death Broncho Pneumonia Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>1</u>	<u>9</u>	hr. _____ min. _____

Due to Influenza 61
 Due to Diabetes mellitus
Mitral regurgitation, arteriosclerosis
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

9. Birthplace Wells County Indiana (City, town, or county) (State or foreign country)
 10. Usual occupation housewife
 11. Industry or business _____

MOTHER FATHER
 12. Name David Shell
 13. Birthplace Ohio (City, town or county) (State or foreign country)
 14. Maiden name Katherine Homan
 15. Birthplace Indiana (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant M. Lepley
 (b) Address Bertrand Mo
 17. (a) Burial (b) Date thereof. 1 24 1941 (Month) (Day) (Year)
 (c) Place: burial or cremation Charleston, Mo.
 18. (a) Signature of funeral director G. A. Simpson
 (b) Address Wilton Mo
 19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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? 715
 _____ (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature M. G. Anderson (M. D. or other) D
 Address Wilton Date signed 1-23-41

RECEIVED

District Health Officer No. 2

District File Number 241-212

Date Filed 2/11/46

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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 G. A. Dempster

Licensed Embalmer No. 2021-

P. O. Address Pikeston Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3460

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 5766

Primary Registration District No. 5764

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Osceola T.P.
(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

Etta Bell Lepley

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

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 _____ year

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

71

1

8

hr. 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) 3-31-41

(Date received local registrar)

(b) F. D. Vernon

(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 Jan day 23
year 1941 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 _____

Duration

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? _____

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

23. Signature M. G. Anderson (M. D. or other)
Address Sikeston mo signed _____

SUPPLEMENTARY

