

No. 2  
-1-4-41  
5-17-39  
PI X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40168

State File No. ....

FILED JAN 15 1943

Registration District No. ....

Primary Registration District No. 5117

Registrar's No. 27

1. PLACE OF DEATH

(a) County Boone  
(b) City or town Columbia Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Columbia Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone  
(c) City or town Cedar T.S.  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Albert EPPERSON

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
7. Name of husband or wife Miriam Little EPPERSON 8. Age of husband or wife if alive 74 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 77 Months Days If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name D K

13. Birthplace D K (State or foreign country)

14. Maiden name White

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

16. (a) Informant E. L. Goodwin

(b) Address 295 Maurice

17. (a) Burial (b) Date thereof Dec 15-42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnson Care

18. (a) Signature of funeral director R. C. ...

(b) Address Columbia

19. (a) Jan 3, 1943 (b) Mrs. Alice ... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13th year 1942 hour 3 P. minute - M.

21. I hereby certify that I attended the deceased from March 25 1941 to Dec 13 1942 that I last saw him alive on Dec 4 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 920

Major findings: Of operations none

Of autopsy none 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 J. C. Suggert (M. D. or other) M.D.

Address Columbia Date signed

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

10  
3  
0

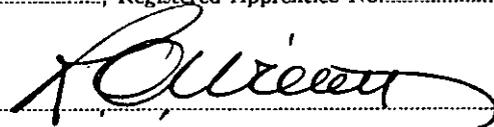
124 Licensed Embalmer's Statement on Reverse Side

**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. 3183

P. O. Address Columbia

**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. 40168

Registration District No. 34

Primary Registration District No. 5117

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Rural  
(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 life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Boone  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Albert Epperson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July Day 13 Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife Martha Epperson 6. (c) Age of husband or wife if 34 years  
7. Birth date of deceased July 16 1886  
(Month) (Day) (Year)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 77 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
10. Usual occupation Farmer  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Martha A White  
15. Birthplace Callaway mo (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) \_\_\_\_\_ (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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

