No. 2
9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1943

Registration District No. _____

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 0429

State File No. 2142

Registrar's No. 28

1. PLACE OF DEATH:
(a) County FRANKLIN
(b) City or town RURAL. LYON T.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Leslie Rural Route Residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(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 0

36 0 0 0

3. (a) PRINT FULL NAME Sophia W.C. Bebemeier

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~~ Fritz H. Bebemeier.

6. (c) Age of husband ~~or wife~~ if alive 68 years

7. Birth date of deceased Oct. (Month) 31. (Day) 1876 (Year)

8. AGE: Years 66, Months 1, Days 18. If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

FATHER
12. Name Henry Kappelmann.
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Louisa Osiek.
15. Birthplace Beaufort (City, town, or county) Mo (State or foreign country)

16. (a) Informant Fritz H. Bebemeier
(b) Address Leslie Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Cosco Mo.

18. (a) Signature of funeral director E. H. Gremme
(b) Address Beaufort Mo.

19. (a) Jan. 14-43 (Date received local registrar) (b) Don Owen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1942 hour 6 minute a. M.

21. I hereby certify that I attended the deceased from Dec 19, 1942, to Dec 19, 1942 that I last saw h~~er~~ alive on Dec 19, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute heart attack	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations No operation
Of autopsy No Autopsy

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

23. Signature T. L. Mallory M.D. (M. D. or other)
Address Beaufort Mo Date signed 12/22/42

1159 (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 E. H. Jemine, Registered Apprentice No. ..... working under my personal supervision.

Signed E. H. Jemine

Licensed Embalmer No. 3076

P. O. Address Beaufort Mo

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2142

Registration District No. 112 Primary Registration District No. 5429 Registrar's No. 28

1. PLACE OF DEATH
(a) County: Franklin
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Sophia W. C. Bebemeier
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
7. Birth date of deceased: Oct (Month) 31 (Day) 1876 (Year)

8. AGE: Years 66 Months 1 Days 18 If less than one day hr. min.

9. Birthplace: (City, town, or county) MO. (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 9 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death Acute heart attack
Due to Chronic Myocarditis
Due to
Other conditions (Include pregnancy within 3 months of death) 93d
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY