No. 2
9-4-41
5-17-39
X29

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3579

FILED FEB 4 1943

Registration District No. 325

Primary Registration District No. 6099

Registrar's No. 46

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

1. PLACE OF DEATH:
(a) County: Schuyler
(b) City or town: Queencity Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None Brame Funk
(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: Schuyler
(c) City or town: Near Queencity
(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 .....

3. (a) PRINT FULL NAME: Max Harold Triplett
3. (b) If veteran, name war: ✓
3. (c) Social Security No. ✓
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased: Dec (Month) 19 (Day) 1942 (Year)

8. AGE: Years 0 Months 1 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace: Near Queencity (City, town, or county) MO (State or foreign country)
10. Usual occupation: None
11. Industry or business: " "
12. Name (Father): Lawerence Triplett
13. Birthplace (Father): Sharidon (City, town, or county) Iowa (State or foreign country)
14. Maiden name (Mother): Emmogene Brown
15. Birthplace (Mother): Lancaster (City, town, or county) MO (State or foreign country)
16. (a) Informant: Lawrence Triplett
(b) Address: Queencity MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 22 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Hazel Creek cemetery
18. (a) Signature of funeral director: Wm H West
(b) Address: Queencity Missouri
19. (a) Jan 22/1943 (Date received local registrar) (b) A. C. Justice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1943 hour 7 minute 10 P.M.
21. I hereby certify that I attended the deceased from Jan 21, 1943, to Jan 21, 1943 that I last saw him alive on Jan 21, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia ✓ — Duration: 5 days
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations .....
Of 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: V. W. Lehr (M.D. or other) D.O.
Address: Queen City, Mo Date signed 1/22/43

1278

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-43-181
Date Filed FEB 3 1943

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 No Embalm

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm. N. West

Licensed Embalmer No. 2882

P. O. Address Queencity MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit 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
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3679

Registration District No. 325 Primary Registration District No. 6099 Registrar's No. 44

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

1. PLACE OF DEATH:
(a) County Schuyler
(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 Max Harold Triplett
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 14 (Month) (Day) 1942 (Year)

8. AGE: Years 0 Months 1 Days 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 Jan Day 21 year 1943 hour 9 minute 10 P. M.
21. I hereby certify that I attended the deceased from Jan 21 Jan 21 1943 to Jan 21 1943; that I last saw him alive on Jan 21 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia primary	1 week
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 107
Of 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)
(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 J. W. Tebe (M. D. or other) D.O.
Address Owen City Date signed March 4, 1943

SUPPLEMENTARY