DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 8 1943

Registration District No. 1925

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19204

Primary Registration District No. 4479

Registrar's No. 66

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERM

1. PLACE OF DEATH:

(a) County: Schuyler

(b) City or town: Queen City, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)

In this community: None

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Schuyler

(c) City or town: Queen City
(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: Isaac Sherman Piper Sr

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Leota Piper

6. (c) Age of husband or wife if alive: 72 years

7. Birth date of deceased: Mar (Month) 29 (Day) 1869 (Year)

8. AGE: Years 74 Months 1 Days 17 If less than one day hr. min.

9. Birthplace: Queen City Mo (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Barber

11. Industry or business: Barber

FATHER

12. Name: Samuel Piper

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

MOTHER

14. Maiden name: Not known

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

16. (a) Informant: George L Piper

(b) Address: Palmyra Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 20 1943 (Month) (Day) (Year)

(c) Place: burial or cremation: Queen City Cemetery

18. (a) Signature of funeral director: Wm M Webb

(b) Address: Queencity Mo.

19. (a) May 20 1943 (Date received local registrar) (b) A A Justice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 18-43 year: 43 hour: 6 PM minute: M.

21. I hereby certify that I attended the deceased from May 18, 1943, to May 18, 1943 that I last saw him alive on May 18, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Brain Hemorrage — Duration: 5 m

Due to: vomiting due to Pleurisy — Duration: 10 hours

Due to: paralysis

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: O. P. Gier (M.D. or other) DO

Address: Queen City Mo Date signed: May 19

127 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-43-983
Date Filed JUN 7 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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Wm H 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 w 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 325 Primary Registration District No. 4479 Registrar's No. 66

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Queen City
(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 Mo (b) County Schuyler

(c) City or town Queen City
(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 Isaac S. Piper Sr

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 M

6. (b) Name of husband or wife Leola

6. (c) Age of husband or wife if alive 72 years

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

8. AGE: Years 74 Months 1 Days 15 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 May day 18
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 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 Brain Hemorrhage

Due to Vomiting due to ptomaine poisoning

Due to Accidental Food Poisoning

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 177

Of autopsy 13

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature A. P. Grow (M.D. or other) DO

Address Queen City Mo Date signed June 12

S-19204