

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 190203

Primary Registration District No. 5734

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Independence Twp  
(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

Janie Epperly

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Mar 14 - 1889  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 4 23 hr. min.

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

10. Usual occupation House Keeper

11. Industry or business.....

12. Name R D McDanel

13. Birthplace Dont know  
(City, town, or county) (State or foreign country)

14. Maiden name Susan

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

16. (a) Informant John Wiggins  
(b) Address RR 1, Macon, Mo

17. (a) burial (b) Date thereof 9/12/43  
(Burial, cremation, or otherwise) (Month) (Day) (Year)

(c) Place: burial or cremation Shiloh Cem - Macon, Mo  
18. (a) Signature of funeral director Albert Skinner  
(b) Address macon, mo

19. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon  
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9  
year 1943 hour 3:45 P.M. minute 3:45 P.M.

21. I hereby certify that I attended the deceased from Sept 9  
1943, to Sept 9, 1943.  
that I last saw him alive on Sept 9, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplectic Coma  
Duration 4 to 6 hrs

Due to.....  
Due to.....

Other conditions Had been subject to previous attacks  
(Includes pregnancy within 3 months of death)

Major findings: 83a!  
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?  
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature G. E. G. G. (M. D. or other).....  
Address Albion Missouri Date signed 9-13-43

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

MOTHER FATHER

APR 8 1953

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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..... *Oelbert Skinner* .....

Licensed Embalmer No..... *75-1* .....

P. O. Address..... *Macori 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.**

Registration District No. 203 Primary Registration District No. 5734

1. PLACE OF DEATH:  
(a) County Macon  
(b) City or town Independence Temp.  
(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) (Specify whether

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town Atlanta Mo. R. 7.10 #2  
(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 Jamie Epperly  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

8. AGE: Years 54 Months 4 Days \_\_\_\_\_ (less than one day) min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 19

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) Oct. 4 (Date received local registrar) (b) Mrs. A. L. Cambre (Registrar's signature)

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. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

32071