G. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1945

Registration District No. 218

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4413

State File No. 3095

Registrar's No.

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Frankford
(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 all of life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike 82

(c) City or town Frankford
(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 MARGARET PIMPEL

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) ~~Single,~~ widowed, ~~married,~~ ~~divorced~~ 2 WIDOWED

6. (b) Name of husband or wife FRANK PIMPEL

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

7. Birth date of deceased JANUARY (Month) 25 (Day) 1859 (Year)

8. AGE:

Years	Months	Days	If less than one day
85	11	11	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

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

MOTHER
14. Maiden name PERMELIA CAMPBELL
15. Birthplace FRANKFORD Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Champ Sykes
(b) Address Frankford, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Fairview Cem. Frankford, Mo

18. (a) Signature of funeral director Fields and Son
(b) Address Frankford, Mo

19. (a) Jan. 8 45 (Date received local registrar) (b) Mrs R. C. Holman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6 year 1945 hour minute M.

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

Immediate cause of death Heart attack

Due to

Due to 95C4

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) Heart attack

(b) Date of occurrence Jan 6 1945

(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? in the home (Specify type of place)

While at work? (e) Means of injury 3

23. Signature S. A. Goodin (M.D. or Other) Coroner

Address Louisiana Mo. Jan 6 Date signed 1945

1169

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-45-294
Date Filed FEB 1 1 1945

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. Jane Fields Megeion

Licensed Embalmer No. 4093

P. O. Address. Frankford 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.