

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 7 1945

State File No. 21457

Registration District No. 323

Primary Registration District No. 4474

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Sweet Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
107 Jefferson Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 46 years
(Specify whether years, months or days)

3. (a) PRINT
FULL NAME

MARIE ALPERS

3. (b) If veteran,
name war ✓

3. (c) Social Security
No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married,
divorced Married
6. (b) Name of husband or wife John F. Alpers 6. (c) Age of husband or wife if
alive 73 years
7. Birth date of deceased September 2 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 29 If less than one day
hr. min.

9. Birthplace Concordia Rural Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business at home

12. Name William Bartels
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Thies
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant John M. Alpers
(b) Address Sweet Springs Mo
17. (a) Burial (b) Date thereof 4 3-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director: Jess H. Harny
(b) Address Sweet Springs
19. (a) April 3 45 (b) Miss Jane Hoffman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Sweet Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 107 Jefferson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1945 hour 8:00 minute 0 A.M.

21. I hereby certify that I attended the deceased from Mar 31
1945 to April 1 1945
that I last saw her alive on April 1 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia Duration 12 hrs
Due to Cerebral Hemorrhage 12 hrs
Due to Arteriosclerosis ?

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 sta-
tistically.

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)
Means of injury

23. Signature J. H. Hale D.O.
Address Sweet Springs Date signed 4-2-45

RECEIVED

District Health Officer No. 8.

District File Number _____

Date Filed 7/6/20

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: _____

Licensed Embalmer No. 2214

P. O. Address Sweet Springs 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.