

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27711

State File No.

Registration District No. 164

Primary Registration District No. 5597

Registrar's No. 69

1. PLACE OF DEATH

(a) County Johnson

(b) City or town Centerview (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Centerview Rural Route # 2, Ind
(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 34 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town Centerview, Mo. Rt 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 Mahlon Oscar Repp

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Edna Lola Repp

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June 19 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>1</u>	<u>16</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business

12. Name Charles W. Repp

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

14. Maiden name Minerva Dry

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

16. (a) Informant Edna Lola Repp

(b) Address Centerview

17. (a) Burial (b) Date thereof Aug 8-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centerview

18. (a) Signature of funeral director W. J. Stewart

(b) Address Warrensburg, Mo

19. (a) Aug 8, 1945 (b) Leola M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 1943
to Aug 5 1945

that I last saw him alive on Aug 2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Struck by lightning immediately

Duration _____

Due to _____

Due to _____

Other conditions Ch. prostatic 4 years
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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) Accident

(b) Date of occurrence 8-5-45

(c) Where did injury occur? in his front yard
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
South, Centerview Mo
(Specify type of place) (e) Means of injury struck by lightning

While at work? _____

23. Signature W. J. Stewart (M. D. or other) _____
Address Warrensburg Mo Date signed 8/7/45

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

MOTHER - FATHER

1001

(Licensed Embalmer's Statement on Reverse Side)

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 Myself
....., Registered Apprentice No.
working under my personal supervision.

Signature Samuel G. Clune
Licensed Embalmer No. 3557
P. O. Address Warrensburg, 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. 164

Primary Registration District No. 5597

1. PLACE OF DEATH:
 (a) County Johnson
 (b) City or town Rural Antwerp
(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)

3. (a) PRINT FULL NAME Mahlon O. Repp
 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 married
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased June 19
(Month) (Day) (Year)
 8. AGE: Years _____ Months _____ Days _____
If less than one day
 hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) Aug 8 1945 (b) Lesla M. Williams
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug Day _____
 year 1945 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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 _____ (M. D. or other)
 Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN

 Underline the cause to which death should be charged statistically.

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

S-27711