

No. 2  
5-43  
-17-39  
X38871

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28297

State File No. \_\_\_\_\_  
Registrar's No. 2078337

FILED AUG 31 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 6038

1. PLACE OF DEATH: *Ripley*

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution: *Rural*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community *41 years*  
years, months or days

3. (a) PRINT FULL NAME *Sarah Walpe*

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 *widowed*

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased *May 30, 1865*  
(Month) (Day) (Year)

8. AGE: Years *81* Months *14* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace *Wayne city Ill.*  
(City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

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

MOTHER FATHER { 12. Name *Peter Walker*

{ 13. Birthplace *unknown a*  
(City, town, or county) (State or foreign country)

{ 14. Maiden name *unknown*

{ 15. Birthplace *unknown r*  
(City, town, or county) (State or foreign country)

16. (a) Informant *E. Lmer Walpe*

(b) Address *Douglas Mo. P#1*

17. (a) *Burial* (b) Date thereof *June 17, 1945*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Amity Cent.*

18. (a) Signature of funeral director *S. W. Edwards*

(b) Address *Douglas Mo.*

19. (a) *8-27-45* (b) *E. O. Johnson*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Ripley*

(c) City or town *Douglas Rural*  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_

(e) Citizen of foreign country? *No.* (Yes or No) *0*

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *15*  
year *1945* hour *10* minute *5* P.M.

21. I hereby certify that I attended the deceased from *6-1-1945* to *June 15*, 1945,  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death *Injured by ship caused by fall.*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following: *91*

(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 *6*

23. Signature *E. O. Johnson* (M. D. or other) \_\_\_\_\_

Address *Douglas, Mo.* Date signed *7/2/45*

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

674

(Licensed Embalmer's Statement on Reverse Side)

no fracture shown by xray but leg was  
edematous up into her abdomen.

J. E. A. Dawson M.D.

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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

*H. G. McHale*

Licensed Embalmer No. *3712*

P. O. Address

*Pacahontas Ark.*

**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. 301

Primary Registration District No. 6032

1. PLACE OF DEATH:

(a) County Ripley  
(b) City or town Rural  
(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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Wolfe

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (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 \_\_\_\_\_

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, Day 18, year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Injured hip caused by a fall

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) Accident

(b) Date of occurrence May-29-1945

(c) Where did injury occur? Rural Ripley, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On farm in home

Paralytic for 2 yrs (Specify type of place)

While at work? her wheel chair (e) Means of injury Fall

23. Signature Edw. Stanton (M. D. or other)

Address Warshaw, Mo. Date signed 9-6-45

SUPPLEMENTARY

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

MOTHER FATHER

5-28297