

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34339**

FILED **08729 1945**

Registration District No. **274**

Primary Registration District No. **3052**

Registrar's No. **283**

1. PLACE OF DEATH:

(a) County **Pettis**
(b) City or town **Sedalia**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Bothwell Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
In this community **5 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **William John Whiprecht**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Anna G. Whiprecht** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 2 1871**
(Month) (Day) (Year)

8. AGE: Years **74** Months **6** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Coatsburg Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Railway Trainman**

11. Industry or business _____

12. Name **August Whiprecht**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Sophia Kieffling**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **S. G. Whiprecht**

(b) Address **Sedalia, Missouri**

17. (a) **Burial** (b) Date thereof **Oct. 22, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **McLaughlin Bros.**

(b) Address **Sedalia, Missouri**

19. (a) **10-23-45** (b) **C. J. Campbell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pettis**
(c) City or town **Sedalia**
(If outside city or town limits, write "RURAL")
(d) Street No. **642 East 5th.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **Native born.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October**, day **20**
year **1945**, hour **12** minute **25**, **A.M.**

21. I hereby certify that I attended the deceased from **October 17-**, 19____, to **October 19 P.M.** 1945;
that I last saw him alive on **October 19, 1945 P.M.** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** Duration **4 days.**
xxx

xx x
Due to **Acute catarrhal cold, of three weeks**
Duration.

Due to **xxxx**

Other conditions **Age.**
(Include pregnancy within 3 months of death)

xxxx
Major findings: **No operation.**
Of operations _____

xxxx
Of autopsy **None made.**

xxxx

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

(a) Accident, suicide, or homicide (specify) **None.**

(b) Date of occurrence **xxxx**

(c) Where did injury occur? **No injury.**
(City or town) (County) (State)

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

xxxx
Specify type of place
While at work **xxxx** (e) Means of injury **xxxx**

23. Signature **C. J. Campbell** (M.D. or other)

Address **112 West 4th St. Sedalia, Mo.** Date signed **10-20-45.**

Date Filed 10-29-65

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

K P M Lary

Licensed Embalmer No.

3153

P. O. Address

Sedalia 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.