

FILED NOV 8 1945

State File No.

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 161

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Rural Washburn Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stah Hosp. No 3-2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 99 or 9 da
In this community Cametubie (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian
(c) City or town Billings
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3. (a) PRINT FULL NAME

Jemima Kapper

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 Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 16 - 1860
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 17 If less than one day _____ hr. _____ /min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name George Kapper
13. Birthplace England 4
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann Peters
15. Birthplace England 4
(City, town, or county) (State or foreign country)

16. (a) Informant H.E. Kapper
(b) Address Billings, Mo
17. (a) Reinterred (b) Date thereof Nov 4, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director J.W. Mages
(b) Address Chewer Missouri
19. (a) 11-2-45 (b) Walter Hanner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2
year 1945 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from 6-4-1945
19____ to 11-2-1945 19____
that I last saw her alive on 11-2-1945 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to arteriosclerosis degeneration

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

Major findings:

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) _____ 108
(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? _____ (c) Means of injury _____
23. Signature R.B. Lester (M.D. or doctor)
Address Nevada Mo Date signed 11-2-45

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

RECEIVED
District Health Officer No. 7,
District File Number 10-45-1081
Date Filed 11-7-45-

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 J.W. Maples
Licensed Embalmer No. 2985-
P. O. Address Chlorine 740

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. 360

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Washington Mo
(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 Jemima
years, months or days

3. (a) PRINT FULL NAME Jemima Wapper

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 16 1862
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days _____ Unless than one day _____ min

9. Birthplace England
(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) (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)

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 Nov day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ 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 _____

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) no.

(b) Date of occurrence Oct. 27-1945

(c) Where did injury occur? Fell on the road, in
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? State Hosp. no. 3 Nevada MO.
(Specify type of place) Means of injury _____

23. Signature P.O. Res... (M. D. certificate) _____
Address _____ Date signed _____

SUPPLEMENTARY

See correction of name of deceased

34926