

S. No. 2
1-8-43
5-17-39
P-1 X37823

34952

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 6 1945
Registration District No. 364

Primary Registration District No. 4237

Registrar's No. 13

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Rural Hickory Grove
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Warren
(c) City or town Rural Hickory Grove
(d) Street No. _____
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME MARY CLEMENTINE Jaspering
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 30
year 1945 hour 1 minute 45 A.M.
21. I hereby certify that I attended the deceased from May
1944 to October 30, 1945
that I last saw her alive on October 30, 1945
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Clarence O. Jaspering
(c) Age of husband or wife if alive 45 years
7. Birth date of deceased: April 29 1901
(Month) (Day) (Year)

Immediate cause of death Acute Myocardial Infarction Duration 5 yrs
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy No

8. AGE: Years 44 Months 6 Days 1
If less than one day _____ hr. _____ min.

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Pender Nebraska
10. Usual occupation House wife
11. Industry or business _____

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? _____
(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 _____
23. Signature John P. Gilliam M.D.
Address Wright City, Mo Date signed 11/1/45

12. Name Crato A. Wupperman
13. Birthplace St. Louis Mo
14. Maiden name Martha Gannaway
15. Birthplace St. Charles Co Mo
16. (a) Informant G O Jaspering
(b) Address Wright City Mo
17. (a) Burial (b) Date thereof 11-2-45
(c) Place: burial or cremation Wright City Cem
18. (a) Signature of funeral director Wright City Mo
(b) Address _____
19. (a) Nov 1 - 1945 (b) Mrs. A. W. Hughes
(Date received local registrar) (Registrar's signature)

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

9

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-5-45

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, ~~XX~~.....

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

Signed Julius J. Nieburg
Licensed Embalmer No. 33066
P. O. Address Wright City 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.