S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 14 1946

State File No. 40376

Registration District No. 2 — Primary Registration District No. 4007 — Registrar's No. 25

1. PLACE OF DEATH:

(a) County Andrew.

(b) City or town 4 Miles N.E. of Cosby-Mo. (If outside city or town limits, write "RURAL" and name of township) Memory

(c) Name of hospital or institution: 4 Miles N.E. of Cosby Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 6 Years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew.

(c) City or town Cosby Mo. (If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. 1 Helena Missouri. (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Sebastian Zepp.

3. (b) If veteran, name war X

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Della May Zepp.

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

7. Birth date of deceased December (Month) 25 (Day) 1875 (Year)

8. AGE: Years 69 Months 11 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace Buchanan County (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation Farmer.

11. Industry or business Farming.

FATHER
12. Name John Zepp.
13. Birthplace Unknown. (City, town, or county) Germany. (State or foreign country)

MOTHER
14. Maiden name Georgia Ann Dillard.
15. Birthplace Unknown (City, town, or county) Missouri. (State or foreign country)

16. (a) Informant Mrs Della May Zepp.
(b) Address R.F.D.1 Helena Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery.

18. (a) Signature of funeral director Herman W. Sydenfaden
(b) Address 1802 Union St. St. Joseph Mo.

19. (a) 12/26/45 (Date received local registrar) (b) Lillian Sparks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21st year 1945 hour 6 minute 00 P.M.

21. I hereby certify that I attended the deceased from Dec. 21, 1945 to Dec. 21, 1945; that I last saw him alive on Dec. 21, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration

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) .....

(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: Dr. W. E. Maxwell (M. D. or other) DO

Address Cosby, Mo. Date signed 12/28/45

1426 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number _____
Date Filed _____

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 Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St Joseph M

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.