. S. No. 2
DM—8-43
v. 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

40636

FILED JAN 8 1946

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1402

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether
In this community 6 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Andrew 2
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Rosendale, Mo. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Peter Jackson Sipes
3. (b) If veteran, name war None
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 Ollie Jane
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased March (Month) 11 (Day) 1863 (Year)

8. AGE: Years 82 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Rosendale (City, town, or county) Missouri. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Own Farm

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name Nancy Ware
15. Birthplace Unknown (City, town, or county) Penn. (State or foreign country) 1

16. (a) Informant Mr. F. C. Sipes
(b) Address Forest City, Missouri.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Oregon, Missouri.
18. (a) Signature of funeral director Herman W. Schuefadin
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) Dec. 28, 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 23 year 1945 hour 6 minute 00 P.M.
21. I hereby certify that I attended the deceased from Dec 17, 1945, to Dec 23, 1945 that I last saw him alive on Dec 22, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic bilateral pyelonephritis
Due to Hypertrophy of Prostate gland
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.

1370

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 Charles Greenberg (M. D. ~~or other~~)
Address Ar. Bldg St. Joseph Mo Date signed 12/26/45

1428

(Licensed Embalmer's Statement on Reverse Side)

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 Herman W. Siedenfaden

Licensed Embalmer No. 2728.

P. O. Address St Joseph 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.