

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

27604

FILED SEP 10 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 175

Primary Registration District No. 3036 of _____

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Lawrence MO

(b) City or town Aurora MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Madison Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community none years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence MO

(c) City or town Aurora MO
(If outside city or town limits, write "RURAL")

(d) Street No. Madison Ave
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Albert Ruppel

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

4. Sex M 5. Color or race W

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

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

6. (b) Name of husband or wife _____

7. Birth date of deceased Nov 9 (Month) (Day) (Year) 1872

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>10</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Businessman

MOTHER FATHER { 12. Name Simon Ruppel ✓

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

14. Maiden name Anna Schiller

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

16. (a) Informant Loane Ruppel

(b) Address Aurora MO

17. (a) burial (b) Date thereof Sept 4 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wash Park

18. (a) Signature of funeral director Paul Marsh

(b) Address Aurora MO

19. (a) Sept 4 (b) Ord McEneaney (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18 year 1946 hour about 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from after death, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature Herman Swiridge (M.D. or other)

Address Aurora MO Date signed 8/19/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

157

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 946-947

Date Filed SEP 9 - 1946

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.....

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

Signed

Licensed Embalmer No. 3872

P. O. Address

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 86

Registration District No. 175

Primary Registration District No. 3036

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Murora
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Albert Reppel

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 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 _____

7. Birth date of deceased mn. 9 (Month) (Day) (Year)

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

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

10. Usual occupation Retired

11. Industry or business Businessman

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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Dr. Mc Natt (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 _____ Day 18
year 1946 (hour) _____ (minute) _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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) _____

(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

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