

No. 3
 OM-5-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33450**
 Registrar's No. **4341**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **22 days**
 In this community **50 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **515 E. 14 St.**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Valentine Boepler**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **15**
 year **1946** hour **4** minute **15 P.** M.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Mary Boepler**
 6. (c) Age of husband or wife if alive ***** years
 7. Birth date of deceased **2 14 1866**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Sept. 23 1946 to Oct. 15 1946;
 that I last saw him alive on **Oct. 15 1946;**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	80	8	1	hr. min.

Immediate cause of death
Post operative cholecystectomy
Generalized peritonitis

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

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

10. Usual occupation **Carpenter**

Major findings:
 Of operations _____
 Of autopsy **See above**

11. Industry or business _____

12. Name **Valentine Boepler**
 13. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

14. Maiden name **Margaret Kaul**
 15. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. James T. Miller**
 (b) Address **1517 Colorado**

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **10-17-1946**
 (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Muncie Leavenworth Mo.**

18. (a) Signature of funeral director **Mrs. C. L. Forster**
 (b) Address **Kansas City, Missouri**

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? _____

19. (a) **10-16-46** (Date received local registrar) (b) **Heraldine Holman** (Registrar's signature)

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature **Wm W. Hart** (M. D. or other) **10-16-46**
 Address **Med. Dir. Gen'l Hosp.** Date signed _____

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

Dr. White

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

Signed *Theron A. Redman*

-Licensed Embalmer No. 2737

P. O. Address *R. L. Moore*

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.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149Primary Registration District No. 1002Registrar's No. 4341

1. PLACE OF DEATH:

- (a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution:
Gen. Hosp #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. (Specify whether

In this community.....
years, months or days)3. (a) PRINT FULL NAME Valentine Boeppler

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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

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

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

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

10. Usual occupation.....

11. Industry or business.....

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) 10-16-46 (b) Gertrudine Holmes
(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 Oct day 15
year 1946 hour 4 minute 150 M.21. I hereby certify that I attended the deceased from Sept 23 1946 to 10-15 1946
that I last saw him alive on 10-15 1946
and that death occurred on the date and hour stated above.Immediate cause of death post operative cholecystectomy
Due to generalized peritonitis

Due to.....

Other conditions..... 126
(Include pregnancy within 3 months of death)Major findings: gall stones
Of operations.....Of autopsy..... above

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 Wm. W. Hart (M. D. or other).....Address Gen. Hosp #1 Date signed 10-16-46

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33450**

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
 (b) City or town.....
(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.....
years, months or days)

3. (a) PRINT FULL NAME

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

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

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

9. Birthplace.....
(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) (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)
(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.....
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
, 19....., to....., 19.....;
 that I last saw h..... alive 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.....

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..... (M. D. or other).....
 Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD