No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 20 1947

Registration District No. 3947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36712

Registrar's No. 2159

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 5124 Lode Av. 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St Louis 96

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

(d) Street No. 5124 Lode Av.
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Margaret Sippel

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife, Henry Sippel

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

7. Birth date of deceased Nov. (Month) 12. (Day) 1860 (Year)

8. AGE:

Years	Months	Days	If less than one day
86	10	27	..... hr. ..... min.

9. Birthplace Germany (City, town, or county) 4 (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John Volz
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Christina Kallert
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant Leona Speis
(b) Address 5124 Lode Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hill Cem.

18. (a) Signature of funeral director Witt Bros. L & N Co
(b) Address 2929 S. Jefferson Av.

19. (a) 10-12-47 (Date received local registrar) (b) Cecilia Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9
year 1947 hour 12 minute noon M.

21. I hereby certify that I attended the deceased from April 1, 1947 to Oct. 9, 1947
that I last saw her alive on Oct. 8, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute dilatation of heart.	15 min
Due to Chronic endocarditis and myocarditis	years
Due to	
Other conditions (Include pregnancy within 3 months of death)	

92d

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN

Underline the cause of 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 0

23. Signature D I Johnson (M. D. ~~or other~~) M.D.

Address 2801 Chippewa Date signed 10-9-47

Jefferson City Printing Co. (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 Davis, Registered Apprentice No. ....., working under my personal supervision.

Signed Edgar F. Mitt

Licensed Embalmer No. 2117

P. O. Address 2929 S Jefferson Ave

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.