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FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2131

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 40

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Pettis</u>                       |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Pettis 90</u> |  |
| b. CITY OR TOWN <u>Sedalia</u>                                     | c. LENGTH OF STAY (in this place) <u>65 yrs</u> | c. CITY OR TOWN <u>Sedalia</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6466.5<sup>th</sup></u> |   | d. STREET ADDRESS (If rural, give location) <u>646 E. 5<sup>th</sup> St.</u>  |  |

|                                     |                        |                          |                            |   |
|-------------------------------------|------------------------|--------------------------|----------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Anna</u> | b. (Middle) <u>Grace</u> | c. (Last) <u>Whiprecht</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 31, 1949</u> |
|-------------------------------------|------------------------|--------------------------|----------------------------|---|

|                      |                               |  |  |   |  |   |
|----------------------|-------------------------------|--|--|---|--|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Sept. 21, 1880</u> | 9. AGE (in years last birthday) <u>68</u> | IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> | IF UNDER 2 HRS. Hour <u></u> Min. <u></u> |
|----------------------|-------------------------------|--|--|---|--|---|

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Coatsburg, Ill.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|---|-----------------------------------|--|---|

|  |   |                             |
|--|---|-----------------------------|
| 13a. FATHER'S NAME <u>August Whiprecht</u> | 13b. MOTHER'S MAIDEN NAME <u>Sophie Keeling</u> | 14. NAME OF HUSBAND OR WIFE |
|--|---|-----------------------------|

|   |                                   |  |                                    |
|---|-----------------------------------|--|------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>No</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>D. G. Whiprecht</u> | ADDRESS <u>1303 So. Monticello</u> |
|---|-----------------------------------|--|------------------------------------|

|  |  |                 |                                  |
|--|--|-----------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |                 | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocardial degeneration</u>  |                 | <u>2 yrs.</u>                    |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Chronic muscular Rheumatism</u><br>DUE TO (c) <u>osteoarthritis</u> |                 | <u>2 yrs.</u>                    |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Gastritis</u>   |  | <u>8 months</u> |                                  |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>107<sup>th</sup></u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 4-2, 1948, to 1-31, 1949, that I last saw the deceased alive on 1-31, 1949, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

|  |                                 |                                  |
|--|---------------------------------|----------------------------------|
| 23a. SIGNATURE (Degree or title) <u>W. F. Bess, M.D.</u> | 23b. ADDRESS <u>Sedalia Mo.</u> | 23c. DATE SIGNED <u>2-1-1949</u> |
|--|---------------------------------|----------------------------------|

|   |                         |  |   |
|---|-------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>2-2-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u> | 24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u> |
|---|-------------------------|--|---|

|  |  |   |                            |
|--|--|---|----------------------------|
| DATE REC'D BY LOCAL REG. <u>2-2-49</u> | REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Bros</u> | ADDRESS <u>519 So. Che</u> |
|--|--|---|----------------------------|

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-11-49

MAR 25 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed [Signature]

Licensed Embalmer No. 3153

P. O. Address [Signature]

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.