

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032076

FILED VS. OCT 13 1959/28

Primary Registration District No. \_\_\_\_\_

Registrar's No. 1040

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>					
b. CITY (If outside corporate limits, give TOWNSHIP, if in OR TOWN <u>Rogersville TWP</u> )		Length of stay in 1b		c. CITY OR TOWN <u>Rogersville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R#1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Attison</u> Last <u>Klepper</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 10, 1877</u>		9. AGE (last birthday) <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Greene Co, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
13a. FATHER'S NAME <u>Robert Klepper</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>			14. NAME OF <del>husband</del> OR WIFE <u>Myrtle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Myrtle Klepper, Rogersville, Mo.</u>		Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>							<u>5 years</u>		
DUE TO (c) <u>Generalized arteriosclerosis</u>							<u>5 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>4-14-54</u> to <u>10-2-59</u> and last saw him <u>7-31-59</u> alive on <u>7-31-59</u>				Death occurred at <u>6:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>1630 N. Jefferson Springfield, Missouri</u>				22c. DATE SIGNED <u>10-5-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 4, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holland Cemetery</u>		23d. LOCATION (City, town, or county) <u>Rogersville Rural, Missouri</u>		(State) _____	
24. FUNERAL DIRECTOR <u>H. C. Ferrell, Rogersville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-6-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REGISTERED STA

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Don S. Jewell

Licensed Embalmer No. 4847

P. O. Address Mansfield, N.H.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.