

**FEDERAL BUREAU OF INVESTIGATION**  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 21 1960

**60-041277**

ENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 451 STATE FILE NUMBER

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>CAPE GIRARDEAU</u>   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u> |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>  |   | Length of stay in 1b <u>11 DAYS</u>  | c. CITY OR TOWN <u>ORAN, MISSOURI</u>  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSPITAL</u>  |   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>CHURCH STREET</u> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ANNIE M. KLIPPEL</u>   |   |  | 4. DATE OF DEATH Month Day Year<br><u>NOV 12 1960</u>  |  |  |
| 5. SEX <u>FEMALE</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>6-20-1888</u>  | 9. AGE (last birthday) <u>72</u>                                   | IF UNDER 1 YEAR Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>  | 11. BIRTHPLACE (City and state or country) <u>NEW HAMBURG, MO.</u>   | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>                        |  |
| 13a. FATHER'S NAME <u>WILLIAM ESSNER</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>MAGDELINA LOGRAND</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>ANDY KLIPPEL</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 Address <u>ANDY KLIPPEL, ORAN, MISSOURI</u>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute thrombophlebitis</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</u>  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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"/>    |  | 20a. 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>10-31-60</u> to <u>11-12-60</u> and last saw her <u>alive</u> on <u>11-12-60</u><br>Death occurred at <u>7:10 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |  |  |  |  |
| 22a. SIGNATURE (Degree or title) <u>Donald J. Smith M.D.</u>   |   |  | 22b. ADDRESS <u>Cape Girardeau Mo</u>  |  | 22c. DATE SIGNED <u>11/16/60</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 23b. DATE <u>NOV. 15, 1960</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>NEW GUARDIAN ANGELS</u>  | 23d. LOCATION (City, town, or county) <u>ORAN, MISSOURI</u>  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>EARL J. SMITH, ORAN, MISSOURI</u>  |   | 25. DATE RECD. BY LOCAL REG. <u>11-16-60</u>   | 25. REGISTRAR'S SIGNATURE <u>Gene Kasten</u>   |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 7 1950

**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 *Earl J. Smith*

Licensed Embalmer No. 2676

P. O. Address ORATE, MISSOURI

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.