

DEB AUG 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

27041
Do not use this space.

1. PLACE OF DEATH ²
 (a) County Sullivan Registration District No. _____
 (b) Township _____ Primary Registration District No. 8 6-1
 (c) City Humphreys (d) Street No. 4517 Registered No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Louis Frank Schweppe
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Whit 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Josephine Schweppe

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 25-1856

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>82</u>	<u>10</u>	<u>12</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Morgan Co. Ill.

FATHER

13. NAME Peter Schweppe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Lottie Leightman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Josephine Schweppe Humphreys Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Henry C. Regan Mo DATE July 9 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. Baynson

20. FILED July 11 1939 Cordelia Shores Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7 1939

22. I HEREBY CERTIFY, That I attended deceased from July 7 1939, to July 7 1939
 I last saw him alive on July 7 1939. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) H. E. Bowers M. D.
West Mo 770 (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

105
4
0

1 X14028

RECEIVED

District Health Officer No. 10

District File Number 9-39-1395

Date Filed AUG 7 1939

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,

R. K. Payne Jr

....., or by

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

Signed.....

R. K. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Salt Mo

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, above space should be left blank.