

NOV 22 1959

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

35690  
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3009  
 (c) City Cape Girardeau (or) Street No. 57 Registered No. 350  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. Francis Hospital  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  Wickham mo  
 (Usual place of abode, if no street address, write county or city) (if nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Guy Gaultner  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-7-1918  
 7. AGE YEARS 21 MONTHS 9 DAYS 2 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. House work  
 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) Bloomfield Mo.

FATHER 13. NAME Lahn P. Prappier  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bloomfield Mo.

MOTHER 15. MAIDEN NAME Sylvia Herrell  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Morris Prappier  
Sikeston Mo. R#1

18. BURIAL, CREMATION, OR REMOVAL PLACE Sikeston mo DATE 10-10 1959

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hunter, Albritton  
Sikeston mo.

20. FILED 10-9 1959 J. M. Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-9 1959

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 12:30 am.  
 The principal cause of death and related causes of importance were as follows:

Ecchymosis & convulsions  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 146

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) D. B. Blood M. D.  
 (Address) Cape Girardeau mo.

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.

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35640  
Registrar's No. 350

Registration District No. .... Primary Registration District No. ....

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

1. PLACE OF DEATH:  
(a) County Cape Girardeau  
(b) City or town Cape Gir  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Gertrude Frankner  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years  
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER { 12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH Month Oct. 9 day 24  
year..... hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death  
claustric c  
convulsions  
Due to.....  
Due to.....  
Other conditions..... (Include pregnancy within 3 months of death)  
Pregnant at time  
Delivery. Mother in critical condition  
Major findings  
of operations  
(dead) Mother expired few hrs  
after

Duration  
PHYSICIAN  
Underline the cause to 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?  
While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature D. B. Elrod (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

