

Registration District No. **477**

Primary Registration District No. **200**

Registrar's No. **57**

1. PLACE OF DEATH:

(a) County **Lewis**
(b) City or town **Rural Labelle, Mo.**
(c) Name of hospital or institution: **none**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **35** (Specify whether years, months or days) **yr.**
In this community: **2** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lewis**
City or town **Rural - near Labelle**
(If outside city or town limits, write "RURAL")
(d) No. **0** (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Charles O. Jarpein

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **28th**
year **1940** hour **8** minute **0** M.

21. I hereby certify that I attended the deceased from **Oct 26-1940**
Oct, 19**40**, to **19**;
that I last saw him alive on **Oct. 28**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral occlusion
Due to **arterio-sclerosis**

Duration

few
months

Due to

Other conditions **9413**
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**
(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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **A. J. McNeil** (M. D. or other) _____
Address **Labelle Mo.** Date signed **10/30/40**

3. (b) If veteran, name war _____

3. (c) Social Security No. **2956323**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Hellie S. Jarpein** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **May 29 1884**
(Month) (Day) (Year)

8. AGE: Years **56** Months **4** Days **29** If less than one day _____ hr. _____ min.

9. Birthplace **Green County, Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Benjamin Jarpein**

13. Birthplace **France**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Johnson**

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

16. (a) Informant **Mrs Charles O Jarpein**

(b) Address **Labelle, Mo.**

17. (a) **Buried** (b) Date thereof **Oct 30 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bourbon Cemetery**

18. (a) Signature of funeral director **James T. Goddard**

(b) Address **Labelle Mo.**

19. (a) **Oct 31, 1940** (b) **O. W. Jennings**
(Date received local registrar) (Registrar's signature)

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

RECEIVED
OCT 29 1940

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.....

Norman D. Cochrane, Registered Apprentice No.
working under my personal supervision.

Signed *Norman D. Cochrane*

Licensed Embalmer No. *3721*

P. O. Address *LaBelle 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.

Registration District No. 477

Primary Registration District No. 200

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town La Belle T.P.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Chas. O. Tarpein
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 56 Months 4 Days 9 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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) May 30, 1946 (b) P. W. Jennings
(Date received by registrar) (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Oct day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions (include pregnancy within 9 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

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 _____
Signature A. H. Hillard (M. D. or other) _____
Address La Belle Mo _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

10000

S-39105 1940