

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Centerview, Mo.
(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 68 yrs years, months or days

3. (a) PRINT FULL NAME Jane Mary Repp

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife J. E. Repp

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Dec 18 1861
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 8 If less than one day _____ min.

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

10. Usual occupation Housekeeper

MOTHER FATHER

11. Industry of business _____

12. Name John Rowland

13. Birthplace Unknown Va
(City, town, or county) (State or foreign country)

14. Maiden name Jane Sliser

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

16. (a) Informant Miss Maid Repp

(b) Address Centerview, Mo.

17. (a) Burial (b) Date thereof Jan 27 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centerview

18. (a) Signature of funeral director Sweeney-Phillips

(b) Address Warrensburg, Mo.

19. (a) Jan 27 42 (b) G. M. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town Centerview
(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 Jan - day 26
year 1942 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Dec 31 1941 to Jan 24 1942
that I last saw her alive on Jan 25 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
secondary

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 108
Of operations _____

Of autopsy _____

Duration 2 wks

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 C. H. Harrison (M. D. or other) _____
Address Warrensburg, Mo. Date signed 1-27-42

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

RECEIVED

Health Officer No. 8,

File Number

Filed 2-11-42

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

R. Q. Phillips

Registered Apprentice No.

working under my personal supervision.

Signed R. Q. Phillips

Licensed Embalmer No. 23201

P. O. Address Warrington, 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, fact should be so stated above.