

FILED JUN 22 1947  
Registration District No. 159

Primary Registration District No. 6000

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

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1. PLACE OF DEATH:

(a) County **St. Charles**

(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Callaway Hosp**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **none** (Specify whether  life) (Specify whether years, months or days)

In this community **life**

3. (a) PRINT FULL NAME **Josephine Seper**

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No: \_\_\_\_\_

4. Sex **F** race **W**

5. Color or race **W**

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

6. (b) Name of husband or wife: \_\_\_\_\_

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

7. Birth date of deceased **Jan 23 1929**  
(Month) (Day) (Year)

8. AGE: Years **13** Months **4** Days **5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St. Charles Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Steve Seper** 4

13. Birthplace **Austria** (State or foreign country) 4

14. Maiden name **Louise Lang**

15. Birthplace **Austria** (State or foreign country) 4

16. (a) Informant **Mrs Seper**

(b) Address **Defiance Mo**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **May 30 1947** (Month) (Day) (Year)

(c) Place: burial or cremation **Cottville, Mo**

18. (a) Signature of funeral director **Martin Manning**

(b) Address **Wentzville, Mo**

19. (a) **May 29 1947** (Date received local registrar)

(b) **Drew Richman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Charles**

(c) City or town **Rural** 92  
(If outside city or town limits, write "RURAL")

(d) Street No. **Near New Melle, Mo** 8  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **May** 28 day **28** year **1947** hour **9:00** minute **PM** M.

21. I hereby certify that I attended the deceased from **5/20 1947** to **5/28 1947**

that I last saw him **5/27** alive on **5/27** and that death occurred on the date and hour stated above.

Immediate cause of death: **Subacute bacterial endocarditis** Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: **9/10**  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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)

Means of injury \_\_\_\_\_

23. Signature **A.C. McMuray** (Physician's name, D. or other) **MD**

Address **Wentzville, Mo** Date signed **5/27/47**

**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 Maris Maskey  
Licensed Embalmer No. 2481  
P.O. Address Wentzville, 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.**