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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 21 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1482

State File No.

Registrar's No.

Registration District No. 24

Primary Registration District No. 5088

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Appleton City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 1/2 mi. west of Appleton City
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 7.2 yrs.
(Specify whether years, months or days)

In this community 7.2 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Cl

(c) City or town Appleton Ct. Mo. (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. 1 1/2 mi. west of Appleton City
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mary Ellen Piepmeyer

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1942 hour 2 minute a M.

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Apr. 20 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 25 1942 to Dec 23 1942
that I last saw him alive on Dec 21 1942
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 8 Days 2
If less than one day hr. min.

Immediate cause of death Uremic Coma
Apoplexy

Due to

Due to

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

10. Usual occupation house maid

Other conditions (include pregnancy within 3 months of death)

11. Industry or business

MOTHER FATHER { 12. Name F W Piepmeyer

{ 13. Birthplace St. Charles, Co., near St. Louis, Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Juliana Gilbreath

{ 15. Birthplace Appleton City, Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

16. (a) Informant Bess Piepmeyer

(b) Address Appleton City, Mo.

17. (a) Burial (b) Date thereof Dec 24 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City

18. (a) Signature of funeral director Oran Eckhoff

(b) Address Appleton Ct. Mo.

19. (a) Dec 24, 1942 (b) Mrs. Wilbert Steiner
(Date received local registrar) (Registrar's signature)

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 R. L. Hanson (M. D. or other) MD

Address Appleton City, Mo. Date signed Dec 24 42

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

1303

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 71

District File Number 12-42-13 81

Date Filed 1-12-43

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 Oscar Edhoff

Licensed Embalmer No. 3242

P. O. Address Appleton City, Wis.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1482

Registration District No. 27

Primary Registration District No. 5088

Registrar's No.

1. PLACE OF DEATH: *Bates*

(a) County.....

(b) City or town..... *Rural*
(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 *Mary Ellen Pappalardo*

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..... *S*

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

7. Birth date of deceased *apr 28*
(Month) (Day) (Year)

8. AGE: Years *73* Months *8* Days..... If less than one day min.

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

10. Usual occupation.....

11. Industry or business.....

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* year *1942* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death *Uremia coma*
apoplexy

Due to *Chronic Nephritis*

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings:
Of operations..... *1318*

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature *Carl Hansen* (M. D. or other) *MD*

Address *Poppleton St* Date signed *2-28-43*

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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