

FILED NOV 10 1944  
23

Registration District No. \_\_\_\_\_

Primary Registration District No. 5087

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County BATES HOWARD TWP  
(b) City or town RT RICH HILL 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 22 years / \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BATES  
(c) City or town RTD Rich Hill mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WALTER P PROPECK

3. (b) If veteran, name war 1 3. (c) Social Security No. 7

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased MAR-22-1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FARMER

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

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

16. (a) Informant Joseph Propeck

(b) Address Rich Hill mo

17. (a) Burial (b) Date thereof 10-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel

18. (a) Signature of funeral director Booths

(b) Address Rich Hill mo

19. (a) 11-3-44 (b) Mrs Margret Shaw  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 28  
year 1944 hour 8 minute 20 A.M.  
21. I hereby certify that I attended the deceased from Sept 10th  
1944 to Oct 28th 1944  
that I last saw him alive on Oct 28 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Cerebral Hemorrhage

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

Other conditions J30  
(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)  
(e) Means of injury \_\_\_\_\_

23. Signature Taylor P. Miller (M. D. or other) D.D.  
Address Erk - Bldg Rich Hill Date signed 10-30-44

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

RECEIVED

Embalmer Officer No. 7

License No. 1-0-44-1386

Date Filed 11-9-44

---

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

*John L. Underwood*

Licensed Embalmer No. 3585

P. O. Address. *Butler 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1111

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Bates  
(b) City or town Rural Harvard Twp  
(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 Walter P. Prepech

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 CM

6. (b) Name of husband or wife PEARLES PROPOCK 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March 12 1878  
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 12 (If less than one day, \_\_\_\_\_ min.)

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local 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 \_\_\_\_\_ year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

33618