

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH Jefferson
County Rock
Township _____ or _____
Village _____ or _____
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 423 File No. 1709A
Primary Registration District No. 5578 Registered No. 1

FULL NAME William L. Pipkin [If death occurred in a hospital or institution, give its NAME instead of street and number]

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|--|--|--|---|--|
| SEX <u>Male</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED <u>MARRIED</u> (Write the word) | DATE OF DEATH <u>January 9</u> , 191 <u>3</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>June 14</u> , 18 <u>75</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from <u>May</u> , 191 <u>2</u> , to <u>Jan 9</u> , 191 <u>3</u> , that I last saw him alive on <u>Jan 6</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>4²⁰ P.</u> m. | |
| AGE <u>37</u> yrs. <u>6</u> mos. <u>25</u> ds. | | | The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u> | |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u> | | | Duration _____ yrs. _____ mos. _____ ds. | |
| BIRTHPLACE <u>Mo.</u> (City or town, State or foreign country) <u>St. Louis Co near Jeffersonton</u> | | | Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. | |
| PARENTS | NAME OF FATHER <u>J. W. Pipkin</u> | | (Signed) <u>W. L. Pipkin</u> M. D. | |
| | BIRTHPLACE OF FATHER <u>Mo.</u> (City or town, State or foreign country) <u>Jefferson Co near Moravia</u> | | <u>Jan 11</u> , 18 <u>73</u> (Address) <u>Kennett Mo</u> | |
| | MAIDEN NAME OF MOTHER <u>Anna Ames</u> | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. | |
| | BIRTHPLACE OF MOTHER <u>Mo.</u> (City or town, State or foreign country) <u>St. Louis City</u> | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. W. L. Pipkin</u> (ADDRESS) <u>Kennett Mo</u> | | | Where was disease contracted if not at place of death? Former or usual residence _____ | |
| Filed <u>Jan 11</u> , 191 <u>3</u> , <u>W. L. Pipkin</u> REGISTRAR | | | PLACE OF BURIAL OR REMOVAL <u>Rehoboth Cemetery</u> DATE OF BURIAL <u>Jan 12</u> , 191 <u>3</u> UNDERTAKER <u>W. G. Koch</u> ADDRESS <u>Sea Fort #4</u> | |

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



PLACE OF DEATH

County

Jefferson

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Township

Registration District No.

File No.

1709-4V

Village

Primary Registration District No.

Registered No.

City

(NO.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

Wm L. Lipkin

PERSONAL AND STATISTICAL PARTICULARS.

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

(Month)

(Day)

(Year)

May 9 1913

DATE OF BIRTH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

, 191 , to , 191 ,

AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than
1 day, _____ hrs.
or _____ min.

that I last saw h alive on _____, 191 ,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

*Cerebral hemorrhage (apoplexy)
Cause unknown*

(Duration)

yrs. *8* mos. _____ ds.

Contributory

(SECONDARY)

(Duration)

yrs. _____ mos. _____ ds.

(Signed)

M J F Kink M. D.
Jan 11 1913 (Address) *Kansas*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

Jan 11 1913 *M J F Kink*

REGISTRAR

Original file, date

Jan 11 1913

All information called for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

W. J. H. Kink

J. H. Kink

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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