

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

31246

1 PLACE OF DEATH

County

Township

or

Village

or *St. Louis*

City

Registration District No. *1005*

File No. *9422*

Primary Registration District No. *4960*

Registered No. *Laclede Frisco Hospital*

(NO. *4960* St. *Laclede Frisco Hospital*)

Ward *9*

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

2 FULL NAME *Arthur C. Lipspe*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *married*
(Write the word)

6 DATE OF BIRTH *June 14 1885*
(Month) (Day) (Year)

7 AGE *40* yrs. *3* mos. *20* ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *clerical*
(b) General nature of industry business or establishment in which employed (or employee) *Frisco R. R.*

9 BIRTHPLACE (City or town, State or foreign country) *Mo.*

PARENTS 10 NAME OF FATHER *Quintel Lippe*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Germany*
12 MAIDEN NAME OF MOTHER *Louis Clausen*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Mrs. Fred Lippe*
(Address) *4258 Shaw*

15 Filed *OCT -9 1925* 191... *Mar 6 Stark*

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *October 5 1925*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Oct 5 1925* to *October 5 1925* that I last saw him alive on *October 5 1925* and that death occurred, on the date stated above, at *1:35 p.m.*

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Apoplexy
7401

CONTRIBUTORY (Secondary) *arterial Hy pertension*
(Duration) yrs. mos. ds.

(Signed) *Chas. E. ...* M. D.
Oct 5 1925 (Address) *4960 Laclede*

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

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

Where was disease contracted if not at place of death?

Former or usual residence *4258 Shaw Ave*

19 PLACE OF BURIAL OR REMOVAL *Mo. Crematory* DATE OF BURIAL *Oct 10 1925*

20 UNDERTAKER *Mullen Und. Co.* ADDRESS *5165 Helmar*

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.

