JUL 27 1927

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

Do not use this space.

1. PLACE OF DEATH
County Lewis — Registration District No. 477 — File No. 18777
Township — Primary Registration District No. 4286 — Registered No. 25
City Canton (No. ... St. ... Ward)

2. FULL NAME Clara Tripp
(a) Residence. No. ... St., ... Ward. ... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Tripp

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 18 - 1888

7. AGE: Years 38 — Months 11 — Days 13 — If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife 139E 79A
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wisconsin

PARENTS
10. NAME OF FATHER: Christopher Thompson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Norway Sweden
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT (Address): John Tripp Warsaw Ill

15. FILED 6-29 1927 H. W. Harris REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 22 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1927 to June 22, 1927 that I last saw her alive on June 22, 1927, and that death occurred, on the date stated above, at 3 23 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral meningitis following an abdominal operation in Feb.
(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (SECONDARY) ...
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Adams Co Ill
1 DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb 1927
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Signs & Symptoms
(Signed) Geo L McCall, M. D
6-23, 1927 (Address) Canton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Canton Mo — DATE OF BURIAL: June 24 1927

20. UNDERTAKER: H D Kelly — ADDRESS: Canton Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Lewis Registration District No.: 477 File No.:
Township: Primary Registration District No.: 4286 Registered No.: 23
City: Canton No.: St.: Ward)

2. FULL NAME: Clara Prikep

(a) Residence. No.: (Usual place of abode) St.: Ward. (If nonresident give city or town and State)

*Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F 4. COLOR OR RACE: W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 8/8, 1927 [illegible] Harris M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 22 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Meningitis following an abdominal operation for tube complete hysterectomy Dau [illegible] Peacemaker rectum hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
Was not a Pauper or Ward
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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N. B. Information should be applied. AGE should be ... CAUSE ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGIST. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-18777