

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

Do not use this space.

36532

1. PLACE OF DEATH  
 County Greene Registration District No. 318  
 Township Springfield Primary Registration District No. 2001  
 City Springfield (No. 1151, State State) St. State Ward State  
 2. FULL NAME Stephan M. Lipscomb  
 (a) Residence. No. 1151 State St., \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (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 M 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED child  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28 - 1925  
 7. AGE YEARS 2 MONTHS 6 DAYS 11 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work child  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Anderson  
 (STATE OR COUNTRY) Mo.  
 10. NAME OF FATHER Brice Lipscomb  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.  
 (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER Carl Anderson  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.  
 (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Brice Lipscomb  
 (Address) Springfield Mo.  
 15. 12/9/27 Octford Mo.  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/9 19 27  
 17. I HEREBY CERTIFY, That I attended deceased from 12-5, 1927, to 12-9, 1927  
 that I last saw h. alive on 12-8, 1927, and that death occurred, on the date stated above, at 1 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Pneumonia  
1088 / 1011 W  
81 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY Pneumonia actinobacillus  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Earl Brand, M. D.  
12/9, 1927 (Address) Springfield 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 Anderson Mo. DATE OF BURIAL 12/10 19 27  
 20. UNDERTAKER Alma Schreyer ADDRESS Springfield 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.

DEPARTMENT RECORD

1-1928

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