

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

Do not use this space.

16175

1. PLACE OF DEATH

County Rochester
Township Washington
City Springfield (No. State Hospital # 2)

Registration District No. 85
Primary Registration District No. 1001

File No.
Registered No. 564
St. Ward)

2. FULL NAME

(a) Residence. No. Lippie DuBoise
(Usual place of abode) State Hospital # 2 Ward.

Length of residence in city or town where death occurred 4 yrs. 2 mos. 20 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)

Married

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

Geo. R. House

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

Unknown 85/1

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

77

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

Retired

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

14.

INFORMANT

Hospital Records
State Hospital # 2

FILED

1928

REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

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

May 4 1928

17.

I HEREBY CERTIFY, That I attended deceased from Apr 25, 1928, to May 4, 1928 that I last saw her... alive on May 4, 1928, and that death occurred, on the date stated above, at 1:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Insufficiency 186H
174 B
9245

(duration) 4 yrs. mos. ds.
CONTRIBUTORY Exhaustion from
(SECONDARY) fracture hip accidentally fell
(duration) yrs. mos. ds.
on floor

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? At

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. J. Carter, M. D.

May 4, 1928 (Address) State Hospital # 2, Springfield

*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

Kansas City, Mo. May 5, 1928

20. UNDERTAKER

E. C. Siderfaden 602 So. 10th

DATE OF BURIAL

ADDRESS

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.

252

