

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

Do not use this space.

21240

1. PLACE OF DEATH

County Marion
Township Johnson
City _____ (No. _____)

Registration District No. 546
Primary Registration District No. 5735

File No. _____
Registered No. 6
St. _____ Ward _____

2. FULL NAME

Rachel H. Nipp

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 6 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 H R Nipp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 14 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 6 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Marion Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Thos Moreland

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Ky

12. MAIDEN NAME OF MOTHER Elizabeth Spencer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Ky

14. INFORMANT J E Nipp
(Address) Presloper Ok

15. FILED June 18, 1928 Sam a. Warner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-11 1928

17. I HEREBY CERTIFY, That I attended deceased from _____ 1928 to _____ 1928 that I last saw him _____ alive on _____ 1928, and that death occurred, on the date stated above, at _____ p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic tubercular nephritis
13 1/2 years (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) William J. Beer, M. D.
6/12, 1928 (Address) St James 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 Broadway cem. DATE OF BURIAL 6-13 1928

20. UNDERTAKER W E Dickhoder ADDRESS St James

WRITE CLEARLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

