

26 1928

Drs. Spm

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

Do not use this space.

1. PLACE OF DEATH

County Miss.Registration District No. 567Township St. JamesPrimary Registration District No. 4334City East PrairieFile No. 306Registered No. 21282St. 38

Ward

2. FULL NAME

(a) Residence. No. Geo. William Bippus

(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.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

May 21 - 1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

177

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

East Prairie

(STATE OR COUNTRY)

10. NAME OF FATHER

Geo. Bippus

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Wheeler

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Ira Handon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Wheeler

(STATE OR COUNTRY)

14.

INFORMANT Geo. Bippus
(Address) 602 E. Prairie, Mo.

15.

FILED 7-5-28Duffin Hodge

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 28 1928

17.

I HEREBY CERTIFY That I attended deceased from June 26, 1928, to June 28, 1928 that I last saw h. u.v. alive on June 27, 1928, and that death occurred, on the date stated above, at 8:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bacillary Dysentery13 1/2

(duration)

yrs.

mos.

da.

CONTRIBUTORY (SECONDARY)

16 1/2

(duration)

yrs.

mos.

da.

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) E. P. Martin

M. D.

. 19

(Address) Essex 116

*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

Amurston Mo.

DATE OF BURIAL

6/28 - 1928

20. UNDERTAKER

Travis Shelby

ADDRESS

East Prairie Mo.

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.

DBA
and be...
GE should be...
property of...
BRAND...
TRADE...
REGISTERED

**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 Miss.
Township
City East Prairie (No.)

Registration District No. 567
Primary Registration District No. 4334

File No.
Registered No. 38
St. Ward

2. FULL NAME

(a) Residence. No. 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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 (duration) yrs. mos. ds.
(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)

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) Don't know

14.

INFORMANT (Address)

15.

FILED 7-5-28 Duff m Hodges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 1928

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:

CONTRIBUTORY (SECONDARY) (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

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SUPPLEMENTARY

S-21292