

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

Do not use this space.

31672

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **8904**

City.....

Missouri Baptist Home

St. Ward

2. FULL NAME

Mary E. Lippincott

(a) Residence. No. *Pittsfield St.* St., *12* Ward. *Pittsfield St.*
 (Usual place of abode)

Pittsfield St.
 (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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <i>Calvin Merion Lippincott</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>July 2 1880</i>		
7. AGE	YEARS <i>48</i>	MONTHS <i>2</i>
	DAYS <i>4</i>	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>at Home</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 2 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 30, 1928*, to *Sept 2, 1928*, that I last saw him alive on *Sept 2, 1928*, and that death occurred, on the date stated above, at *2:40 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Hyperthyroidism
 Exophthalmic Goiter*

(duration) *1* yrs. - *1* mos. - *1* da.

CONTRIBUTORY (SECONDARY) *WA*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRAICTED
 IF NOT AT PLACE OF DEATH?

0 DID AN OPERATION PRECEDE DEATH? *NO* DATE OF
 WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *A.R. Risher*, M. D.

Sept 2, 1928 (Address) *4480 Westminster*
 *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.

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

10. NAME OF FATHER *Thomas Harrison*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo.*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Lelah Williams*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *IL*
 (STATE OR COUNTRY)

14. INFORMANT *Collin M. Lippincott*
 (Address) *Pittsfield St.*

15. SEP - 4 1928
 FILED 19 *Mary C. Starkloff*
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Pittsfield St.* DATE OF BURIAL *Sept 4 1928*

20. UNDERTAKER *Philandy Gray* ADDRESS *4468 Washington*

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.

