

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

Do not use this space.

25912

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No. *Josephine Hospital*)

File No.
Registered No. **7091**
St. Ward)

2. FULL NAME

Frances Ripping *Ripping*

(a) Residence. No. *6427 Vermont a* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov-12-1858*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 7 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at home*
(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) *Germany*

PARENTS

10. NAME OF FATHER *Wes*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14.

INFORMANT *Jane Robinson*
(Address) *6427 Vermont a*

15.

FILED 19 *May C Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 3* 19 *29*

17. HEREBY CERTIFY, That I attended deceased from *June 7*, 19 *29* to *July 3*, 19 *29*.
(That I last saw him/her alive on *July 3*, 19 *29*, and that death occurred, on the date stated above, at *4-45 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
*Reulms - celtic
chronic myeloiditis*

CONTRIBUTORY (SECONDARY) *Parasymptoma*
myeloiditis chronic
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *no.* DATE OF

WHAT TEST CONFIRMED DIAGNOSIS *clinical*
(Signed) *W. J. ...* M. D.
7/5, 19 *29*, (Address) *7605 E. Midway*

*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 *St Peter & Paul* DATE OF BURIAL *7-6* 19 *29*

20. UNDERTAKER *Southern* ADDRESS *7315*
S. Brady

WRITE PAINLY, 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.

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General