

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

Do not use this space.

40669

1. PLACE OF DEATH

County Jackson
Township Low
City N. C. Mo. (No. St. Marys Hosp.)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 50114
St. _____ Ward) _____

2. FULL NAME

Malissa M. Pippenger
(a) Residence. No. 8053 Michigan 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female White Widow

4. COLOR OR RACE

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

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

Pete Pippenger

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

July 10 1859

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>70</u>	<u>4</u>	<u>29</u>	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Jno. Pippenger

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

12. MAIDEN NAME OF MOTHER Varma May Welch

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

14. INFORMANT M. P. Pippenger
(Address) 8053 Michigan

15. FILED 179 19. 29 M. M. Crowe
REGISTRAR usr

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec - 9 - 1929

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Dec 9, 19 29, that I last saw her alive on Dec 8, 1929, 10 and that death occurred, on the date stated above, at 3:45 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 chronic interstitial nephritis
2 chronic myocarditis
131
93 Calant (duration) 10 yrs. mos. ds.
107A bronchopneumonia
(SECONDARY) (duration) _____ yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Do not know
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS clinical, laboratory
(Signed) Jesse R. Haley, M. D.

*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 Forest Hill **DATE OF BURIAL** Dec 10, 1929

20. UNDERTAKER Mrs. C. L. Foster **ADDRESS** N. C. Mo.

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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1062 Medical Arts
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