

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

Do not use this space.

20146

47

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County New Madrid Registration District No. 871  
Township East Primary Registration District No. 3801  
City New Stanton St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lipie Rose Townsend

(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**

**4. COLOR OR RACE**

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

Female White Child

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

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

Sept 16 1926

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
3	8	20	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(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)**

Mathews  
Missouri

**10. NAME OF FATHER**

William C. Townsend

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

Mt. Vernon  
Indiana

**12. MAIDEN NAME OF MOTHER**

Mary Beville

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

Paradise  
Missouri

**14. INFORMANT (Address)**

W. P. Townsend  
Hardhouse, Mo.

**15. FILED**

7/7/30  
Walter E. News  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** June 5 1930

**17. I HEREBY CERTIFY, That I attended deceased from** June 4  
\_\_\_\_\_, 1930, to June 4, 1930.  
that I last saw her alive on June 4, 1930, and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Streptococci Acute Throat

115A  
109B1 (duration) \_\_\_\_\_ yrs. mos. 10 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 \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Physical  
(Signed) Thomas C. M. Cleere, M. D.

, 19 (Address) Sebaston, 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**

Sebaston Cemetery  
Mathews, Mo. June 10 1930

**20. UNDERTAKER** John Aboultou  
ADDRESS Sebaston, 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.

