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

Do not use this space.

31836

1. PLACE OF DEATH
County Madison — Registration District No. 538
Township — Primary Registration District No. 3028
City Fredericktown (No. ....., ... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME Josie Tripp
(a) Residence (Usual place of abode) No. ..... St., ... Ward. ..... (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)
F.	W.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 30 - 1901

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	9	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Fredericktown
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER John McCarver
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Minnie Palite
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mine La Motte
(STATE OR COUNTRY) Mo

14. INFORMANT E. B. Tripp
(Address) Fredericktown Mo

15. FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 11 1931

17. I HEREBY CERTIFY, That I attended deceased from 9-8, 1931, to 9-11, 1931, that I last saw ~~her~~ alive on 9-11, 1931, and that death occurred, on the date stated above, at 12:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Post partum hemorrhage following Child birth
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (SECONDARY) Puerperal eclampsia
(duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) H. Harry Barron, M. D.
9/12, 1931 (Address) Fredericktown 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 Christian Cemetery, Fredericktown — DATE OF BURIAL 9/12 1931

20. UNDERTAKER E. H. Webb — ADDRESS Fredericktown Mo

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: Madison — Registration District No.: 338 — File No.:
Township: — Primary Registration District No.: 3-0-8 — Registered No.:
City: Fredericktown, ... St. ..... Ward)

2. FULL NAME: Josie Tripp
(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)

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 .....
(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)

PARENTS
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)

14. INFORMANT .....
(Address)

15. FILED 9 30, 19 31. C. U. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/11 19 31

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:
.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.
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

SUPPLEMENTARY

...Y ARE COMPLETE AS PRESCRIBED BY LAW
...SPACE NOT RECEIVE A FEE FOR CERTIFICATES UNTIL

5-31836