

WRITE PLAINLY, 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.

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

Do not use this space.

FEB 8 1935

1. PLACE OF DEATH

County Pemiscot
Township State Mo
City State Mo (No. _____) St. _____ Ward _____

Registration District No. 655
Primary Registration District No. 4392

File No. 5972-2
Registered No. _____

2. FULL NAME

Mary Junice Lipscomb
(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 10 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Child</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u> </u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 27-23</u>		
7. AGE	YEARS	MONTHS
		<u>9</u>
		<u>27</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u> </u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u> </u>		
10. Date deceased last worked at this occupation (month and year) <u> </u>		
11. Total time (years) spent in this occupation. <u> </u>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>State Mo</u>		
FATHER	13. NAME <u>Barney Lipscomb</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lexington Mo</u>	
MOTHER	15. MAIDEN NAME <u>Kim Hindstaf</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lexington Mo</u>	
17. INFORMANT <u>Orin Lipscomb</u> (ADDRESS) <u>State Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Mission</u> DATE <u>2-25</u> 19 <u>35</u>		
19. UNDERTAKER <u>Bernard J. Co</u> (ADDRESS) <u>State Mo</u>		
20. FILED <u>3/1</u> 19 <u>35</u> <u>Max P. Kelly</u> Registrar.		

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-28 1935

22. I HEREBY CERTIFY, That I attended deceased from 2-10 1935 to _____, 19____
I last saw alive on 2-28 1935 Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Broncha Pneumonia Date of onset _____
107A
Other contributory causes of importance:
Whooping Cough & Measles

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) J. B. Wood _____, M. D.
(Address) State Mo

