

**UNITED STATES BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

12085
File No. 15
Registered No. 15

MAY 25 1934

1. PLACE OF DEATH
 County Caldwell Registration District No. 95
 Township Linsler Primary Registration District No. 4057
 City Cowgill Mo No. _____ St. _____ Ward _____

2. FULL NAME Elizabeth Hennes Kiple
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 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 OR (OR) WIFE OF Isaac P. Kiple

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 1 -

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>77</u>	<u>11</u>	<u>29</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Iowa

10. NAME OF FATHER Isaac P. Kiple

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

12. MAIDEN NAME OF MOTHER Elizabeth H. Smith

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1 1934

17. I HEREBY CERTIFY, That I attended deceased from March - 10, 1934, to April 1st, 1934 that I last saw her alive on March 29, 1934, and that death occurred, on the date stated above, at 6:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
arterio Sclerosis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Fall and severe shock, (SECONDARY)
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Ockelbourn, M. D.
April 2 1934 (Address) Cowgill 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Kingston</u>	DATE OF BURIAL <u>April 3 1934</u>
20. UNDERTAKER <u>Ch. H. Reed</u>	ADDRESS <u>Cowgill Mo.</u>

14. INFORMANT (Address) Mrs. Pearl Lirtch Cowgill Mo.

15. FILED Apr. 10 1934 Mrs. Ed. M. Cray REGISTRAR

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide, Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

State Board of Health,
Jefferson City, Mo.

Since receiving your last request for added information regarding Mrs. Kipler's death, I've talked to her daughter, Mrs. Pearl Firth with whom she lived. She says they can't tell just how or why she fell as there wasn't any one in the room with her at that time. She was alone in an upstairs room.

Mrs. Firth says the fall had nothing to do with her Mother's death as it was some time before her last sickness. She didn't know the exact date of the fall Mrs. M. C. Gray

S- (2) / 2085

April 1 - 1934

**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 Caldwell Registration District No. 95
 Township Cowgill Primary Registration District No. 4057
 City Cowgill (No. _____) St. _____ Ward _____

File No. -15
 Registered No. 15

2. FULL NAME

Elizabeth Warner Riple
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)

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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 1 1934

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF Frank P. Riple

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 1st 1856

The principal cause of death and related causes of importance were as follows:
Artificial Schlerous Date of onset _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 78 0 0 0

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance:
Fall and reversal of chest

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

13. NAME Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

15. MAIDEN NAME Elizabeth W. Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Mrs. P. Cowgill Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Kingston, Mo. DATE Apr 3, 1934

19. UNDERTAKER (ADDRESS) J. A. Riedy Mo. Cowgill Mo.

20. FILED April 4 1934 Miss Ed. McCray Registrar

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? accident Date of injury _____, 19____
 Where did injury occur? at Mrs. Vartho's home
 (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) O. C. Telbourn, M. D.
 (Address) Cowgill Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

JAN 28 8 1935

FEB 7

1935

have previously given you all
my available information. I sug-
gest you take case up with the attending
physician or some member of their
family.

Craigville, Mo.

Feb. 1st 1935

No broken or fractured
bones - general nervous system
shock. No concussion.

Wm. Ed. Mc
Local Ry

S (B) 18085

Dr. C. C. Kelbourn