

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

Do not use this space.

MAR 21 1935

4642

**1. PLACE OF DEATH**

County Cass  
Township Union  
City (No. ....)

Registration District No. 149  
Primary Registration District No. 4093  
5213

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

James Hamilton Hipshe  
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 13 - 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
67 8 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Tenn  
(STATE OR COUNTRY)

10. NAME OF FATHER Ransom Hipshe

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

12. MAIDEN NAME OF MOTHER Sarah Jane Hays

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

14. INFORMANT Mrs Jessie Hipshe  
(Address)

15. FILED Feb 9, 1935 Geo. E. Myers  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 1935

17. I HEREBY CERTIFY, That I attended deceased from 12-29-1924 to Feb 7-1935 that I last saw him alive on Feb 7-1935 and that death occurred, on the date stated above, at 8:15 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Thrombosis

(duration) .... mos. / .. ds.  
CONTRIBUTORY arteriosclerosis  
(SECONDARY) hypertension  
(duration) .... mos. .. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WHAT TEST CONFIRMED DIAGNOSIS? clinical. Eval.  
(Signed) W. H. Moore, 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 Cleveland Mo  
DATE OF BURIAL Feb 10 1935

20. UNDERTAKER Geo. E. Myers  
ADDRESS Cleveland 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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