

JUL 24 1936

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

Do not use this space.

Dr. Book 23124

1. PLACE OF DEATH
County Jackson Registration District No. 399
Township Kearney Primary Registration District No. 1002
City K.C.Mo (No. 2216 E. 21st.) St. Ward

2. FULL NAME Delia Kipper
(a) Residence, No. 2216 E. 21st. 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.

File No.
Registered No. 3057

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April, 16 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 2 9

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. G.

MOTHER FATHER
13. NAME John Brooks
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. G.
15. MAIDEN NAME Dont Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

17. INFORMANT (ADDRESS) Eva Jarrutt
2216 E. 21st. St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland Cem DATE 6/59/36

19. UNDERTAKER (ADDRESS) West Capital Ins

20. FILED 6/29 1936 M. M. Brown
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25 1936

22. I HEREBY CERTIFY, That I attended deceased from June 12, 1936, to June 25, 1936
I last saw her alive on June 25, 1936. Death is said to have occurred on the date stated above, at 11:58 a.m.
The principal cause of death and related causes of importance were as follows:
Date of onset

Program
Necrosis
Left leg

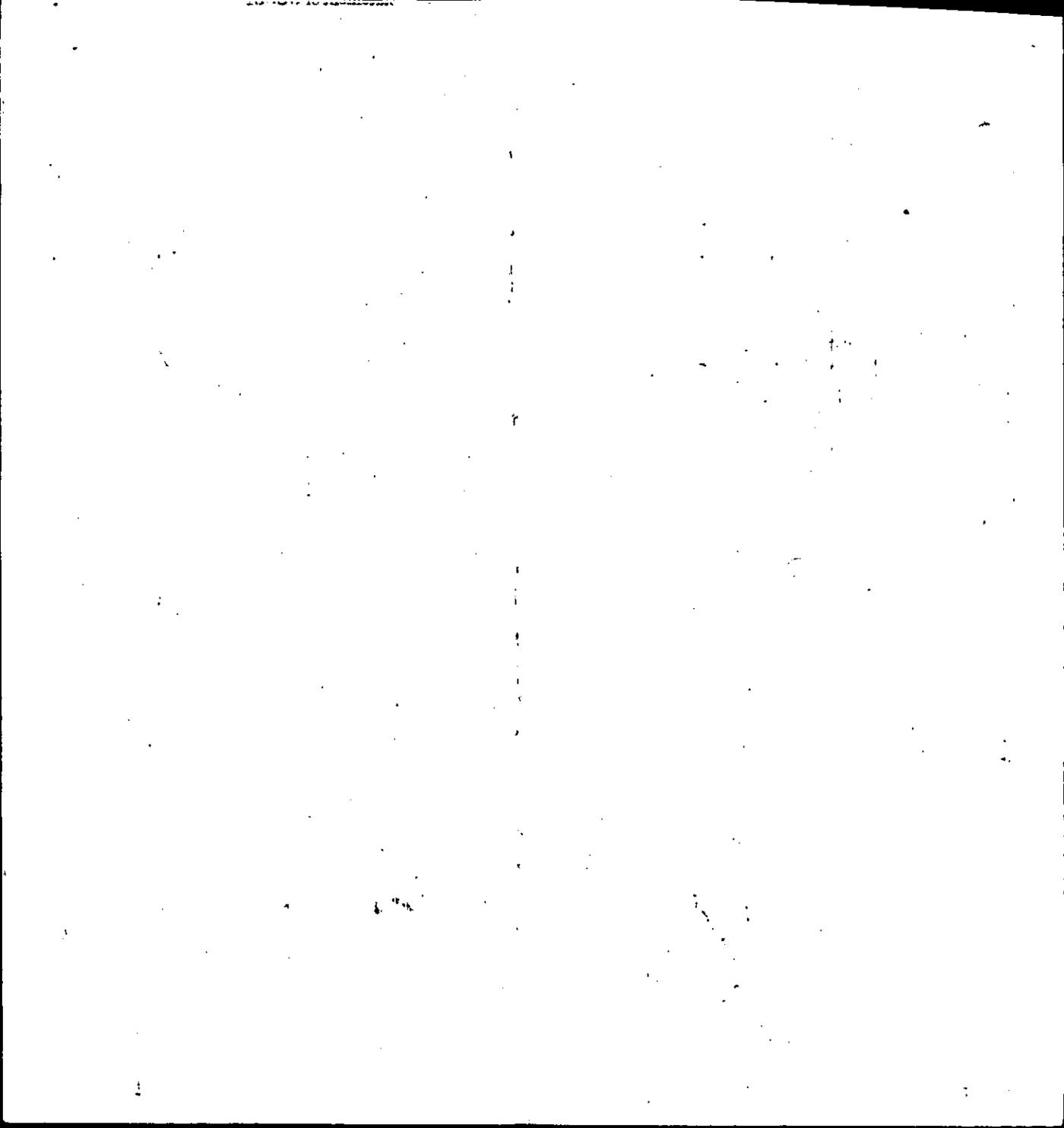
Other contributory causes of importance:
General Septicemia

Name of operation Date of
What test confirmed diagnosis? Phys Exam Was there an autopsy? Yes

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) H. W. Booker, M. D.
(Address) 2028 - Vine St.



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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... No..... St..... Ward.....

File No.....
Registered No. 3057

2. FULL NAME

Helen Ripper

(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. (If nonresident, give city or town and State)

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.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....	11. Total time (years) spent in this occupation.....
	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).....	

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

13. NAME.....

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

15. MAIDEN NAME.....

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

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS).....

20. FILED

6/29 1936 M. H. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)....., 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... 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:

Lungren and
neuropathy of left leg
Diabetic

Date of onset

Other contributory causes of importance:

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) L. W. Booker, M. D.

(Address) 2028 Vine St.

S-23124