

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

33772
Do not use this space.

1. PLACE OF DEATH

(a) County Yernon Registration District No. 875
 (b) Township Washington Primary Registration District No. 0162 Registered No. 237
 (c) City Nevada (d) Street No. State Hospital #3 St.
 (e) Length of residence in city or town where death occurred 4 yrs. 3 mos. 27 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 135 Allen St. Mo. Ripscamp
 (Usual place of abode if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sylvia ? Ripscamp
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 1, 1908
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 9 10
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 10. Date deceased last worked at this occupation (month and year) ? 11. Total time (years) spent in this occupation ?

12. BIRTHPLACE (CITY OR TOWN) Dark County, Mo.
 (STATE OR COUNTRY)

FATHER 13. NAME R. E. Lipscomb

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

MOTHER 15. MAIDEN NAME Sophia Jacobs

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

17. INFORMANT (ADDRESS) Records, State Hosp #3

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospital DATE Sept. 13, 1939

19. FUNERAL DIRECTOR (NAME) Ferry Funeral Home
 (ADDRESS) Nevada, Mo.

20. FILED Sept. 12, 1939 Allen, Mo. Hays
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1937, to Sept. 11, 1939
 I last saw him alive on Sept. 11, 1939 Death is said to have occurred on the date stated above, at 2:45 p.m.
 The principal cause of death and related causes of importance were as follows:

Date of onset 1911
Manicacal Exhaustion
 Other contributory causes of importance: Acute Bronchitis, Pneumonia, Pharyngitis, Sinusitis
Sept. 12, 1939

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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? No
 If so, specify _____
 (Signed) Reuben H. Pottinger M. D.
 (Address) Nevada, 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.

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1450

Date Filed 10-11-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed M E Ferry

Licensed Embalmer No. 11432

P. O. Address Nevada, N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.