

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

8487

Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875
 (b) Township Washington Primary Registration District No. 6162 Registered No. 47
 or 3
 (c) City Nevada (d) Street No. STATE HOSPITAL #3 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ABRAHAM H. LIPE

(a) Residence, No. R. Goodman Mo. St. R. Goodman Mo.
 (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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Laura Kinchelow Lipe
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 10, 1858
 7. AGE YEARS 82 MONTHS 3 DAYS 28 If LESS than 1 day, hrs. or min.

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.
 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) Unknown

FATHER 13. NAME HARRISON LIPE

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

MOTHER 15. MAIDEN NAME Charollite H. Hanson

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

17. INFORMANT (ADDRESS) STATE HOSPITAL #3 RECORDS

18. BURIAL, CREMATION, OR REMOVAL PLACE Goodman Mo DATE 2-12 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas W. Williams Goodman Mo.

20. FILED 2-16 1940 Allen V. Karp Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 11, 1940

22. I HEREBY CERTIFY, That I attended deceased from 2/5, 1940, to 2/11, 1940.
 I last saw him alive on Feb 11, 1940. Death is said to have occurred on the date stated above, at 2:35 A.
 The principal cause of death and related causes of importance were as follows:

Bronchopneumonia

Date of onset

2/5/40

Other contributory causes of importance:

myocarditis
senility

Name of operation none Date of

What test confirmed diagnosis? examet Was there an autopsy? no

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) Paul L. Barone M. D.

(Address) State Hospital #3

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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 3-40-337
Date Filed 3-40-40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.