DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21149

FILED JUL 15 1940

Registration District No. 6 Primary Registration District No. 4036 Registrar's No. 25

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Benton

(b) City or town: Warsaw (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Brill's Hill (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: XXXXX (Specify whether years, months or days) In this community: 9 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Benton

(c) City or town: Warsaw (If outside city or town limits, write "RURAL")

(d) Street No.: Brill's Hill (If rural, give location)

(e) If foreign born, how long in U. S. A.? XXXXXX years.

3. (a) PRINT FULL NAME: Doris Arline Flippen 415

3. (b) If veteran, name war: XXXXXX

3. (c) Social Security No.: XXXX

4. Sex: female

5. Color or race: white

6. (a) Single, widowed, married, divorced: XXXX single

6. (b) Name of husband or wife: none

6. (c) Age of husband or wife if alive: XXXXX years

7. Birth date of deceased: June (Month) 24 (Day) 1940 (Year)

8. AGE:

Years	Months	Days	If less than one day
XXXX	XXX	XXX	9 hr. 00 min.

9. Birthplace: Warsaw, Mo (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: none

11. Industry or business: none

MOTHER FATHER

12. Name: Donald Bennett Flippen

13. Birthplace: Climax Springs (City, town, or county) Mo. (State or foreign country)

14. Maiden name: Flavel Gearaldine Brown

15. Birthplace: Warsaw, (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Donald Bennett Flippen

(b) Address: Warsaw, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1940 hour 10 minute 15 A. M.

21. I hereby certify that I attended the deceased from June June, 24, 1940, to June, 24, 1940; that I last saw her alive on June 24, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Mal-formation of the heart — Duration: 9 hrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: (M. D. or other)

Address: Warsaw, Mo Date signed 6/24/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 7-40-1047
Date Filed 7-9-40

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 wit the above constitutes grounds for revocation of license.)

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

No. 2B
2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21149

Registration District No. 61 Primary Registration District No. 4036 Registrar's No.

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Warsaw
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Doris Arline Flippen
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 9 hs. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) Warsaw, Mo (Burial, cremation, or removal) (b) Date thereof 6/24/40 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director none
(b) Address
19. (a) 6/24/40 (Date received local registrar) (b) Jas. A. Logan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 24 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work (e) Means of injury

23. Signature Gus C. Salley (M. D. or other)
Address Warsaw Mo Date signed

SUPPLEMENTARY