

Registration District No.

318

Primary Registration District No.

2001

Registrar's No.

557

1. PLACE OF DEATH  
(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
(years, months or days) /

3. (a) PRINT FULL NAME C. Sipe  
3. (b) If veteran, name war No  
3. (c) Social Security No. None  
4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Martha Emmaline Sipe  
6. (c) Age of husband or wife if alive Dec. years  
7. Birth date of deceased March 9 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 3 25 hr. 5 min.

9. Birthplace near Alton, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business  
12. Name William Sipe  
13. Birthplace near Alton, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. W. W. Carroll  
(b) Address Mammoth Spring, Ark.

17. (a) Burial near Hickory Grove Cem.  
(Burial, cremation, or removal) (b) Date thereof July 7, 40  
(Month) (Day) (Year)  
(c) Place: burial or cremation Hickory Grove Cem.

18. (a) Signature of funeral director Carroll Funeral Home  
(b) Address Thayer, Mo.

19. (a) July 5 1940  
(Date received local registrar) (b) W. E. Handley  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Oregon  
(c) City or town Rural  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4  
year 1940 hour 11 minute 15 P. M.  
21. I hereby certify that I attended the deceased from June 6, 1940 to July 4, 1940  
and that I last saw him alive on July 4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Terminal  
Due to probable, due to Trans. Vascular resection 6-30-40  
Due to \_\_\_\_\_  
Other conditions Senility 127  
(Include pregnancy within 3 months of death)

Duration few days

Major findings:  
Of operations Enlarged prostate gland  
Of autopsy no

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?  
yes  
Where at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
Signature W. E. Handley (M. D. or other) M.D.  
Address Springfield, Mo. Date signed 7-16-40

Dr. Sewell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

**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 \_\_\_\_\_

*Leo Carr*

Licensed Embalmer No. \_\_\_\_\_

*2852*

P. O. Address \_\_\_\_\_

*Thayer, M*

**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.**

*X*

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 25-171  
Registrar's No. 037

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:  
(a) County Greene  
(b) City or town Springfield  
(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  
In this community (Specify whether years, months or days) first name unknown by informant

3. (a) PRINT FULL NAME C. A. Dipe  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife  
6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days 25  
If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER  
12. Name  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant  
(b) Address

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) 9-12-40 (Date received local registrar) (b) N. E. Handley MD (Registrar's signature)

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)  
If born in U. S. A.?

20. DATE OF DEATH Month July day 4 year 1940 hour minute M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 W. J. Sewell (M. D. or other) \_\_\_\_\_  
Address Springfield Date signed \_\_\_\_\_

SUPPLEMENTAL

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

