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

31367
Do not use this space.

1. PLACE OF DEATH (a) County Pettis (b) Township Warrensburg (c) City Near Brownwood Mo (d) Street No. ..... 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.

Registration District No. 69
Primary Registration District No. 5108
Registered No. 31

2. PRINT FULL NAME Lisa Ellen Gipson
(a) Residence, No. Near Brownwood, Mo. St.
(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: Female
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: Henry Gipson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug 5 1902
7. AGE: Years 37 | Months 11 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housewife
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): Stoddard County Missouri

FATHER
13. NAME: Bird Lang
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

MOTHER
15. MAIDEN NAME: Gertie Baker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Bellinger Co. Mo.

17. INFORMANT (ADDRESS): Henry Gipson, Brownwood, Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE: Brownwood, Mo. DATE: July 29, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Hayes & Morgan, Warrensburg, Missouri
20. FILED: 9/23, 1941 Mrs John Barry, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July 28, 1940
22. I HEREBY CERTIFY, That I attended deceased from July 27, 1940, to July 28, 1940
I last saw her alive on July 27, 1940 Death is said to have occurred on the date stated above, at 10 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Puerperal Infection	

Other contributory causes of importance: Malaria

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) E. C. Masters, M.D.
(Address) Advance, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

WHITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1 X14023

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, Lloyd S Morgan, or by _____,

Registered Apprentice No._____, working under my personal supervision.

Signed Lloyd S Morgan

Licensed Embalmer No. 3361

P. O. Address Advance, Mo.

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.

No. 2B
-2-21-40
I 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. 31367

Registration District No. 69 Primary Registration District No. 5108 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Bollinger

(b) ~~City or town~~ Wayne T. P.
(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
In this community years, months or days)

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 Disa Ellen Gipson

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 m

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
	37	11	23	hr. 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) (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 7 day 28
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 Puerperal infection following a delivery by Dr. Reynolds, about 4 weeks earlier

Due to

Due to

Other conditions Malaria
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 145

Duration

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 E. C. Masters (M. D. or other) D.O.
Address Advance Date signed

S. No. 2B
—2-21-40
I X22659

DOWENA MOORE

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. 31367

Registration District No. 69 Primary Registration District No. 5108 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Bollinger
(b) ~~City or town~~ Wayne
(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 Dissa Ellen Gipson
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 M
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 37 Months 11 Days 23 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 28 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.

Duration

Immediate cause of death Puerperal infection from a delivery made by Dr. Reynolds
Due to N. B. Advanced 2 weeks prior to death
Due to
Other conditions malaria
(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?
While at work? (Specify type of place) (e) Means of injury

23. Signature E. C. Masters (M. D. or other) MD
Address Advance, Mo. Date signed July 3, 1940