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DEC 11 1940

Registration District No. **834**

Primary Registration District No. **60103**

Registrar's No. **37**

3
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: **Stoddard**

(a) County **Stoddard**

(b) City or town **Rural New Lisbon**
(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**

3. (a) PRINT FULL NAME **Vesta Lipe**

3. (b) If veteran, name war _____

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **James C. Lipe** 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years **68** Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation **Nursekeeper**

11. Industry or business _____

12. Name **Not known**

13. Birthplace **Not known** (City, town, or county) _____ (State or foreign country)

14. Maiden name **Not known**

15. Birthplace **Not known** (City, town, or county) _____ (State or foreign country)

16. (a) Informant **Oliver L Lipe**

(b) Address **1140 Falk Ave, Maplewood, Mo**

17. (a) **Burial** (b) Date thereof **Nov 6, 1940** (Month) (Day) (Year)

(c) Place: burial or cremation **Leaves Cemetery, Mo**

18. (a) Signature of funeral director **Harold W. Moya**

(b) Address **Advance, Mo**

19. (a) **Dec 7 - 1940** (Date received local registrar) (b) **D. S. Mc Kee** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **Near Advance, Mo**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **5** year **1940** hour **6** minute **2** 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 **Heart failure**

Due to **lived alone**

Due to **not seen for 2 weeks**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **200 N**

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? **758** (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **John Williams** (M. D. or other) _____

Address **W. Springfield, Mo** Date signed **11/9/40**

RECEIVED

District Health Officer No. 2

District File Number 1240-1791

Date Filed 12/9/40

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.....

Floyd D. Morgan

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

working under my personal supervision.

Signed.....

Floyd D. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance

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, fact should be so stated above.