DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28070

Registr[illegible] [illegible]strict No. 201

Primary Registration District No. ~~5280~~ 5012

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution 124 Maple St (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none! (Specify whether years, months or days)

In this community 1 year - 4 Months - 28 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 94

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

(d) Street No. 3205 Summit St (If rural, give location)

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

3. (a) PRINT FULL NAME HORACE PORTER STIPES

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ANNA MAY STIPES

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased January (Month) 18 (Day) 1859 (Year)

8. AGE: Years 82 Months 7 Days 11 If less than one day ___ hr. ___ min.

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

10. Usual occupation R. R. Engineer

11. Industry or business

FATHER
12. Name John Daniel Stipes
13. Birthplace Harpers Ferry Va. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Annie B. Davies
15. Birthplace unk. Va (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lillian B. Osborne

(b) Address Liberty, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Hill Brothers

(b) Address Slater, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29 year 1941 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 1 1941, 19__, to Aug 29, 1941; that I last saw h[illegible] alive on Aug 29, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	4 hr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

94

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 Gustenden (M. D. or other)

Address Liberty, Mo Date signed 8/30/41

926

(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.

OCT 6 1941

RECEIVED
District Health Officer No. 8,
Permit File Number 9-9-41
Date Filed

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. A C Hall

Licensed Embalmer No. 3090

P. O. Address Stater, Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

8a

No. 2B
—8-21-41
PI X29288

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

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STANDARD CERTIFICATE OF DEATH

State File No. 28070

Registration District No. 201 Primary Registration District No. 3012 Registrar's No. 82

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Liberty
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Horace P. Styles
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: 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 hrs. 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) Aug 30 1941 (Date received by local registrar) (b) Helen Early (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 29 day
year 1941 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.

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(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 Date signed

SUPPLEMENTARY