

Registration District No. 89 87

Primary Registration District No. 513-15729

Registrar's No. 191

1. PLACE OF DEATH:
(a) County BUTLER
(b) City or town RURAL - BEAVER DAM TWP
(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 MO (b) County BUTLER
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. 6 MI. WEST OF HARVILL
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DOLLIE TRIPP
(b) If veteran, name war _____ (c) Social Security No. _____
4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
7. Birth date of deceased MAR 12 1888
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JUNE day 14 year 1942 hour 12 minute 30 P.M.
21. I hereby certify that I attended the deceased from June 14 1942 to June 14 1942

that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.
Immediate cause of death Heart trouble Duration _____
Dead when I arrived

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>3</u>	<u>2</u>	_____ hr. _____ min.

Due to _____
Due to _____
Other conditions Y
(Include pregnancy within 3 months of death)

9. Birthplace CHICKASAW MISS
(City, town, or county) (State or foreign country)
10. Usual occupation HOUSEWIFE

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings:
Of operations Y
Of autopsy Y

11. Industry or business _____
12. Name THOMAS WHITE
13. Birthplace MISS
(City, town, or county) (State or foreign country)
14. Maiden name ARA GILLISPI
15. Birthplace MISS
(City, town, or county) (State or foreign country)

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

16. (a) Informant Henry Tripp
(b) Address REFUGO Nashville Mo
17. (a) BURIAL (b) Date thereof JUNE 15-1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation SHARE CROPPERS CEM

While at work? No (Specify type of place) (e) Means of injury Y
23. Signature J. J. Farr (M. D. or other) _____
Address Harvill Date signed June 14

18. (a) Signature of funeral director N. J. Wheeler
(b) Address Paylor Bluff Mo
19. (a) 6-20-42 (b) Belle Kenne
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 642-811

Date Filed JUN 23 1942

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

N. J. Phelps

Licensed Embalmer No. 3281A

P. O. Address

Saplar Bluff

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17566

Registration District No. 87

Primary Registration District No. 5129

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Rural
(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

3. (a) PRINT FULL NAME Dollie Lripp

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 Mar 12 1888
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-27-42 (b) Belle Tenne
(Date received local registrar) (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)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 23 Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

(Immediate cause of death) _____

Due to Heart trouble
Mitral stenosis.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J.P. Farr (M. D. or other) _____
Address Albanyville Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

