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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

LED MAR 16 1943

Registration District No. 97

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5353

State File No. 10078

Registrar's No. 4

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

1. PLACE OF DEATH:

(a) County: Dallas

(b) City or town: Rural Jackson twp
(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: Mo (b) County: Dallas Co

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

(d) Street No.: Elkland Mo.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Milburn Lipe

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: S

6. (b) Name of husband or wife: /

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

7. Birth date of deceased: April (Month) 22 (Day) 1879 (Year)

8. AGE: Years 63 Months 8 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace: Dallas Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business .....

FATHER
12. Name: Wm Lipe
13. Birthplace: Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Malinda Burnsides
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: E. E. Taylor
(b) Address: Fair Grove Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Union Mound

18. (a) Signature of funeral director: L. B. Jones
(b) Address: Buffalo Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19 year 1943 hour 3 minute 00 P. 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: Tuberculosis

Due to: Pulmonary

Due to: /

Other conditions (Include pregnancy within 3 months of death): /

Major findings:
Of operations .....
Of autopsy .....

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: D. Stone Coroner (M. D. or other)

Address: Buffalo Mo Date signed 1-19-43

11 2 4

(Licensed Embalmer's Statement on Reverse Side)

43

RECEIVED
District Health Officer No. 7
District File Number 1-43-159
Date Filed 3-2-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

. S. No. 2B
OM—8-21-41
I X29288

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. 10078

Registration District No. 97 Primary Registration District No. 5353 Registrar's No. 4

1. PLACE OF DEATH:
(a) County: Dallas
(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 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: Milburn Lipe
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: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased: April 22 1880 (Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 8 If less than one day hr. min.

9. Birthplace: Mo. (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. Feb 24-1943 (Date received local registrar) Mr Arthur Hoover (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 9 year 1943 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.

Immediate cause of death	Duration
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.

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY