

No. 2
-2-43
-17-39
X35697

FILED FEB 15 1944

Registration District No. _____

Primary Registration District No. 6020

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Ray

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

(c) Name of hospital or institution: RTD #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community entire life years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 89

(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 Elizabeth R. Dudgeon

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased May 20 1925
(Month) (Day) (Year)

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

9. Birthplace Ray Co. (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Isaac Rippe

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Martha Gault

15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant Allen E. White

(b) Address Northmore 706

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 24 44
(Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cemetery

18. (a) Signature of funeral director John W. Knipfchee

(b) Address Haystack

19. (a) Jan 20 1944 (b) Miss Phyllis H. Huppert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20
year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from 12-1-43 19. to 1-20 19. 44
that I last saw her alive on Jan 15, 19. 44
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart Dis. Duration
Myral Regurgitation ?

Due to _____

Due to _____

Other conditions Chronic Nephritis ?
(Include pregnancy within 3 months of death)

Major findings: Of operations 1318
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) (c) Means of injury _____

Signature Geo J. Kern (M. D. & Registrar)
Address Richmond, Mo. Date signed 1-20-44

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

2-14-44

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 me

Registered Apprentice No.

working under my personal supervision.

Signature

John W. Knipschild

Licensed Embalmer No. 2789

P. O. Address. Hardin 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Feb.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ray
(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) PRINTED FULL NAME Elizabeth R. Dudgeon

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 W

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

7. Birth date of deceased May 20 1900
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days _____ 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RAY
(c) City or town NORBORNE PFD # 2
(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 Jan day 20 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him/her 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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

4079