

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7087**

Registration District No. **107**

Primary Registration District No. **3019**

Registrar's No. **31**

1. PLACE OF DEATH:

(a) County **DeKalb**
(b) City or town **Kennett**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **20 yrs** years, months or days

3. (a) PRINT FULL NAME **J. W. Pipkins**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **422-162651**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mary Pipkins** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Nov 19 1871** (Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **McKenzy Tenn - 1** (City, town, or county) (State or foreign country)

10. Usual occupation **Night Watchman**

11. Industry or business _____

MOTHER FATHER { 12. Name **John W. Pipkins**
13. Birthplace **unknown** (City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Mary Pipkins**

(b) Address **206 Court, Kennett, Mo.**

17. (a) **Burial** (b) Date thereof **2-3-1944** (Month) (Day) (Year)

(c) Place: burial or cremation **Kennett Cemetery**

18. (a) Signature of funeral director **Lloyd Russell**

(b) Address **Piggott, Arkansas**

19. (a) **Feb 3 1944** (Date received local registrar) (b) **Julius Blankenship** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **DeKalb**
(c) City or town **Kennett** (If outside city or town limits, write "RURAL")
(d) Street No. **206 W. Everett** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **29** year **1944** hour **8** minute **15 P** M.

21. I hereby certify that I attended the deceased from **Jan 29 1944** to **Jan 29 1944** that I last saw him alive on **Jan 29 1944** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Hemorrhage** 15 minutes

Due to **Ruptured aortic aneurysm**

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

Major findings: Of operations **308**
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) _____
Means of injury **2**

23. Signature **Freight? Gibson D O** (M. D. or other)
Address **Kennett Mo** Date signed **2-1-44**

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

35
2
2

RECEIVED

District Health Office No. 2,

District File Number 344-391

Date Filed 3-3-44

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.....

..... 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.