

FILED JUL 8 1945
Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Isolation Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6-27-44 to 6-30-44
 (Specify whether
 In this community Life
 years, months or Days

3. (a) PRINT FULL NAME John Rippey
 3. (b) If veteran, name war No. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. N
 6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased Nov. 21 1941
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 3 9 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 12. Name John A. Rippey
 13. Birthplace Maurice, Illinois 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Viola Horn
 15. Birthplace St. Louis Mo. 0
 (City, town, or county) (State or foreign country)

16. (a) Informant Honourable Richardson

(b) Address Isolation Hospital

17. (a) Burial (b) Date thereof 7-3-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill C.E.M.

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Ave

19. (a) JUN 30 1944 (b) J. P. Prelect
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Mo.
 (c) City or town St. Louis Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 720 E. Argonne, Kirkwood Mo.
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) N
 If yes, name country

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from 6-27-44
 1944, to 6-30-1944
 that I last saw him alive on 6-30-1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Meningitis
 Duration

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy The Meningitis
 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 W. K. Klingberg (M. D. or other)

Address 3600 Arsenal Date signed 6/30/44

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 3454

....., Registered Apprentice No.

working under my personal supervision.

Signed

David Robinson

Licensed Embalmer No.

3454

P. O. Address

7456 March

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.