

No. 2  
8-43  
7-39  
X37823

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

FILED JAN 9 1945

Registration District No. **206**

Primary Registration District No. **5746**

Registrar's No. **70**

**1. PLACE OF DEATH:**  
 (a) County Madison Co  
 (b) City or town Rural Central Mo  
(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 1  
 In this community most of life years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Madison  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Central Mo  
(If rural, give location)  
 (e) Citizen of foreign country? ✓ (Yes or No)  
 If yes, name country ✓

**3. (a) PRINT FULL NAME** Eliza Gippow  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. ✓

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Dec day 12  
 year 1944 hour 10:30 minute 0 M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_  
 \_\_\_\_\_, 19\_\_\_\_ to Dec 12, 1944  
 that I last saw her alive on Dec 11, 1944, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W  
 6. (a) Single, widowed, married, divorced 2  
 6. (b) Name of husband or wife A. G. Gippow 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased April 19 1857  
(Month) (Day) (Year)  
 8. AGE: Years 87 Months 7 Days 21  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral Emboli Duration 5 days  
 Due to Hypertension  
 Due to \_\_\_\_\_

9. Birthplace North Carolina  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife  
 11. Industry or business Emanuel Hedrick  
 12. Name Emanuel Hedrick  
 13. Birthplace Dickson, N.C.  
(City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown  
(City, town, or county) (State or foreign country)

Other conditions fatal insufficiency  
(Include pregnancy within 3 months of death)  
 Major findings: Questionable Carcinoma  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
 16. (a) Informant Effie E. Casper  
 (b) Address Mill Creek Mo  
 17. (a) Burial (b) Date thereof 12/14/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Christian  
 18. (a) Signature of funeral director Walt & Natl Funeral Home  
 (b) Address Frederickton Mo  
 19. (a) Dec 14 1944 (b) S. C. Slaughter  
(Date received local registrar) (Registrar's signature)

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 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 0  
 23. Signature S. C. Slaughter (M. D. or other) 0  
 Address Frederickton Date signed 12-14-44

RECEIVED

District Health Officer No. 4

District File Number 145-30

Date Filed 1-8-45

**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

*John H. Holt*

Licensed Embalmer No. 4264

P. O. Address Fredonia, Pa.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. gan  
Registrar's No. 70

Registration District No. 206 Primary Registration District No. 5745

1. PLACE OF DEATH:

(a) County Madison

(b) City or town Rural Central mo  
(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 Elyja Lignon

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

4. Sex F 5. Color or race N

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 April 24 1945  
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) N.C.

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) Date \_\_\_\_\_ (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 2 day 12  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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.

Concussion of Brain 2nd

ADDITIONAL SUPPLEMENTARY INFORMATION

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) (a) Means of injury \_\_\_\_\_

23. Signature F. Ed. Williams M.D. (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY INFORMATION

MOTHER FATHER

41589