

FILED FEB 15 1945

Registration District No. 7

Primary Registration District No. 5422

State File No.

Registrar's No. 8

1. PLACE OF DEATH:

- (a) County Dunklin
 (b) City or town Kennett Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: July

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution.
- 1
- (Specify whether

In this community
years, months or days)3. (a) PRINT FULL NAME Rosie Viola Esrippie

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

4. Sex
- Female
5. Color or race
- W
-
6. (a) Single, widowed, married, divorced
- Married

6. (b) Name of husband or wife
- W. J. Esrippie
6. (c) Age of husband or wife if

7. Birth date of deceased
- Sept 4 1886
-
- (Month) (Day) (Year)

8. AGE: Years
- 58
- Months
- 3
- Days
- 1
- If less than one day
-
- hr. min.

9. Birthplace
- London Tenn
-
- (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name
- Wm. C. Chandler

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

14. Maiden name
- Dona Mathis

15. Birthplace
- Tenn
-
- (City, town, or county) (State or foreign country)

16. (a) Informant
- Ethel Lewis

- (b) Address
- Wenton Tenn

17. (a)
- Burial
- (b) Date thereof
- 12-28-44
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation
- Oak Ridge Tenn

18. (a) Signature of funeral director
- L. H. Hall

- (b) Address
- Kennett Mo

19. (a)
- 1-26-45
- (b)
- Julia Blank
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Dunklin
 (c) City or town Kennett Rural
 (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 U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- 12
- day
- 27
-
- year
- 1944
- hour
- 6
- minute
- 30 P.M.

21. I hereby certify that I attended the deceased from
-
- Dec 15, 1944
- to
- Dec 25, 1944
-
- that I last saw her alive on
- Dec 25, 1944
-
- and that death occurred on the date and hour stated above.

Immediate cause of death

Cancer of Stomach 1 yr.Due to I have been theDue to patient Dr. Gipe.Previously she hadbeen in Pressnell'sOther conditions Hospital
(Include pregnancy within 3 months of death)Major findings: Kennett, Mo.
Of operationsOf autopsy 46 b

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

23. Signature
- R. R. Bohler
- (M. D. or other)
- D.O.

Address Kennett Date signed 1-4-45

RECEIVED

District Health Office No.

District File Number 245-16

Date Filed 2-7-45

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.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.
Registrar's No. 8

Registration District No. 107 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Russell Independence Jay
(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 _____ (Specify whether _____)
years, months or days

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 Rosie V. Griffin

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

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

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

7. Birth date of deceased Sept 4 1945
(Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 13 If less than one day _____ min. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 1-26-45 (b) Julia Blankinship
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27
year 1945 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 _____

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

S-2/15