

FILED MAY 10 1945

State File No. \_\_\_\_\_

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 148

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Indian

(c) Name of hospital or institution: State Hospital No. 1

(d) Length of stay: 2 yrs 7m 16 d

In this community 2 yrs 7m 16 d

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Caldwell

(c) City or town Thompson

(d) Street No. \_\_\_\_\_

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME William R. Kipple

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month April day 27 year 1945 hour 1-55 minute 2 M.

21. I hereby certify that I attended the deceased from 3-8-45 to 4-27-45 that I last saw him alive on 4-26-45 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mrs Stella Kipple

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

Immediate cause of death Lobar Pneumonia

Due to arteriosclerosis

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>			hr. _____ min. _____

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace Ill

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Samuel Kipple

13. Birthplace Ill

14. Maiden name Samuel

15. Birthplace Ill

16. (a) Informant Record

(b) Address \_\_\_\_\_

17. (a) Removed (b) Date thereof 5-2-1945

(c) Place: burial or cremation Thompson MO

18. (a) Signature of funeral director Frank Wright

(b) Address Missouri

19. (a) 5-2-1945 (b) Josie M. ...

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? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_

23. Signature George H. Reers (M, D or other) M.D.

Address Fullerton Mo Date 4-27-45

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

14  
1  
2

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-9-45

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 Paul E. Riecht

Licensed Embalmer No. 7189

P. O. Address Mexico 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.