S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34684

FILED NOV 3 1945

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2507

1. PLACE OF DEATH:

(a) County Koch ST. LOUIS

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lobt Koch Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 156 days (Specify whether
In this community 23 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County —0-00

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1843 O'Fallon 9
(If rural, give location)

(e) Citizen of foreign country? — Mo (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME Mattie Pippins

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Fem 2

5. Color or race Col

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased 7 (Month) 13 (Day) 20 (Year)

8. AGE:

Years	Months	Days	If less than one day
25	3	12	hr. min.

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

10. Usual occupation Factory Worker

11. Industry or business —

FATHER
12. Name Edward Pippins
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ANNIE BROWN (Miller)
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant [illegible]
(b) Address 1855 O'Fallon St

17. (a) (Burial, cremation, or removal) (b) Date thereof 11-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director H. W. Petty
(b) Address 1245 Glasgow Ave

19. (a) 10-31-45 (Date received local registrar) (b) E. S. McGavran M.D. (Registrar's signature) MSC

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 10 day 25
year 1945 hour 9 minute 32 P. M.

21. I hereby certify that I attended the deceased from 5-22, 1945, to 10-25, 1945;
that I last saw her alive on 10-25-45, 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tbc	10 mo
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Bernard Friedman (M. D. or other) MD
Address Lobt Koch Hosp Date signed 10/25/45

(Licensed Embalmer's Statement on Reverse Side)

APR 9 1947

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.