S. No. 2
I—9-4-41
r. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 11 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42820

Registration District No. 379 Primary Registration District No. 4553 Registrar's No.

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Mansfield
(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 3 yrs 10 mo, 18 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright 114

(c) City or town Mansfield 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME James Barney Rippee

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Nancy Ward Rippee

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Jan (Month) 30 (Day) 1872 (Year)

8. AGE:

Years	Months	Days	If less than one day
73	10	18	hr. min.

9. Birthplace Wright Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Well Driller

11. Industry or business

FATHER
12. Name Thomas Rippee
13. Birthplace Wright Co (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Elizabeth Rippe
15. Birthplace Wright Co (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Nancy Rippee
(b) Address Mansfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mansfield Cem

18. (a) Signature of funeral director F. A. Stiffe
(b) Address Mansfield Mo.

19. (a) 12/28/45 (Date received local registrar) (b) Irene C. Hicks (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 18
year 1945 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from 12/11, 1945, to 12/18, 1945
that I last saw him alive on 12-16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hemmorhage of Brain

Due to

Due to

Other conditions Mitral Insufficiency
(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.

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 0

23. Signature [signature] (M. D. or other)

Address [illegible] Date signed 12/27 1945

1558

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 146-46
Date Filed JAN 9 1946

57/8.c/c)

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 F. A. Steffe

Licensed Embalmer No. 3221

P. O. Address Mansfield 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.