No. 2
I—2-43
5-17-39
I X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6176

FILED MAR 12 1946

Registration District No. 6

Primary Registration District No. 3127

Registrar's No. 36

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

5159

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: 827 West 4th St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 46 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 4

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

(d) Street No. 827 West 4th St. 6
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Ruth Triplett Craig

3. (b) If veteran, name war none

3. (c) Social Security No. [illegible]

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife widow

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

7. Birth date of deceased December (Month) 23 (Day) 1890 (Year)

8. AGE: Years 55 | Months 2 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Kansas City (City, town, or county) Kansas 1 (State or foreign country)

10. Usual occupation Secretary

11. Industry or business Public Schools

FATHER
12. Name T.C. Triplett 1
13. Birthplace ..... (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Isabelle Layman
15. Birthplace ..... (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Frank Triplett (Bro) Webb City
(b) Address 435 South Madison Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28-46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Hedge-Leurs
(b) Address Webb City Mo

19. (a) FEB. 28; 46 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 26
year 1946 hour 5 minute 55 P.M.

21. I hereby certify that I attended the deceased from 2-2, 1946, to 2-26, 1946
that I last saw her alive on 2-26, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death [illegible] (chronic [illegible])	
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 [illegible] (M. D. or other) M.D.

Address Webb City Mo Date signed 2-28-46

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(Licensed Embalmer's Statement on Reverse Side)

46-2-177

MAR 19 1946

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.