

FILED FEB 28 1946

Registration District No. 169

Primary Registration District No. 5623

Registrar's No. 23

1. PLACE OF DEATH:

(a) County KNOX
 (b) City or town Salt River Inn
 (If outside city or town limits, write "RURAL" and name of township)
Rural 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 One year
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Knox 52
 (c) City or town Rural 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. near Novelty mo 0
 (If rural, give locality)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country ✓

3. (a) PRINT FULL NAME Charley Harsess Pipes

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 514096659

4. Sex Male 5. Color or race W
 6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased Feb 28, 1887
 (Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 1 If less than one day ✓ hr. min.

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

10. Usual occupation Day Laborer

11. Industry or business ✓

12. Name Andrew Pipes (1)
 13. Birthplace Sullivan Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Pipes Cagana
 15. Birthplace Sullivan Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Hennrich Pipes
 (b) Address Novelty, Mo.

17. (a) removal (b) Date thereof Jan 29, 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem. Sullivan

18. (a) Signature of funeral director Glen E. Kent

(b) Address Green City, Mo

19. (a) 2-7-46 (b) Nelle S. Hunsat
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29,
 year 1946 hour 5 minute P. M.
 21. I hereby certify that I attended the deceased from Jan 27,
27, 1946 to Jan 29, 1946
 that I last saw him alive on Jan 27, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis. Duration etc.

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
 Of operations 13/18
 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 0

23. Signature E. H. Buerby (M. D. or other) _____
 Address La Plata Mo. Date signed 1-29-46

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

RECEIVED

District Health Officer No. 10

District File Number 2-46-251

Date Filed FEB 25 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.....

Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address. Green City, 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.

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Registration District No. 169

Primary Registration District No. 5623

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Knox
(b) City or town Rural Salt River
(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 Mo (b) County Knox
(c) City or town Novelty
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Charley H. Pipes

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

Feb 28
(Month) (Day) (Year)

8. AGE:

Years 58 Months _____ Days _____ Unless than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

Day Laborer

12. Name _____

Andrew Pipes

13. Birthplace _____

(City, town, or county) (State or foreign country) MO

14. Maiden name _____

Sarah Cannon

15. Birthplace _____

(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb. - 7 - 46 (b) _____

(Date received local registrar)

Nelle S. Nunest

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 1946 year 2 hour 9 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 _____

Duration

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 A H Buckley (M. D. or other) _____

Address La Plata, Mo Date signed _____

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

SUPPLEMENTARY

