

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32530

Registrar's No. 38

FILED 000
Registration District No. 374

Primary Registration District No. 4547

1. PLACE OF DEATH:

(a) County W. North
(b) City or town Grant city
(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..... 57 yrs
years, months or days)

3. (a) PRINT
FULL NAME

John Henry Gippe
3. (b) If veteran..... 3. (c) Social Security
name was..... No.....

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married
divorced Widowed

6. (b) Name of husband or wife Clara Elizabeth Gippe 6. (c) Age of husband or wife if
alive..... years

7. Birth date of deceased..... 28 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 11 5 hr. min.

9. Birthplace..... Viro Co. Ill. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant & School teacher

11. Industry or business Hardware & Furniture

12. Name William Gippe

13. Birthplace..... Ind. 1
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Halder

15. Birthplace..... Ind. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Gippe

(b) Address Grant city Mo.

17. (a) Burial (b) Date thereof 9-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant city Cem.

18. (a) Signature of funeral director Arch C. Temple

(b) Address Grant city Mo.

19. (a) 9-9-46 (b) Alta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County W. North
(c) City or town Grant city
(If outside city or town limits, write "RURAL")

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

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3
year 1946 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan
5, 1946 to 9-3, 1946
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Carcinoma of rectum 1 yr -

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: ✓
Of operations.....

Of autopsy no

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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) (c) Means of injury II

23. Signature W. H. H. H. (M. D. or other)
Address Cherry City Mo. Date signed 9-4-46

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Arch C. Duffee*.....
Licensed Embalmer No. *3252*.....
P. O. Address *Grant 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.