

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE INSURANCE
FILED NOV 26 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37691

State File No. _____

Registration District No. 200

Primary Registration District No. 5705

Registrar's No. 124

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution St. Hildegard's Catholic Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 10-9-46 to 10-23-46

2. USUAL RESIDENCE OF DECEASED:

(a) State Kennesee (b) County _____

(c) City or town Nashville
(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 _____

3. (a) PRINT FULL NAME NELL WINN LIPSCOMB

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F / 5. Color or race W.

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased January 20 1878
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name William H Winn

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

14. Maiden name Sarah Gubbs

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

16. (a) Informant Sarah W Lipscomb

(b) Address 3010 Market Nashville Tenn

17. (a) burial (b) Date thereof Oct 23 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nashville Tenn

18. (a) Signature of funeral director Robert S Keener

(b) Address Macon Mo

19. (a) Nov 5-46 (b) Ruth Moneely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
year 1946 hour 9:40 minute A.M.

21. I hereby certify that I attended the deceased from Oct. 9 1946 to Oct 22 1946
that I last saw her alive on Oct 22 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to 94A

Other conditions Major depressive psychosis
(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 2

23. Signature R.H. Still (M.D. or other) D.O.
Address Macon Mo Date signed 10/22/46

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

NOV 27 1945

NOV 29 1945

RECEIVED
District Health Officer No. 10
District File Number 10-46-2115
Date Filed NOV 25 1945

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 Albert Skinner
Licensed Embalmer No. 75-1
P. O. Address Macon 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.