

FILED JAN 20 1947

Registration District No. ....

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County: DuPage

(b) City or town: St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution: 1 yr 5 mos 20 days  
(Specify whether in hospital or institution)

In this community: 1 yr 5 mos 20 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson

(c) City or town: St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No.: 913 E 14th St  
(If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: Ruth Kipper

3. (b) If veteran, name war: No

3. (c) Social Security No.: Not

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 12 day: 23  
year: 1946 hour: 4 minute: 10 M.

4. Sex: Female

5. Color or race: Col

6. (a) Single, widowed, married, divorced, separated: Separated

6. (b) Name of husband or wife: Wm Kipper

6. (c) Age of husband or wife if Not known years

7. Birth date of deceased: Aug 11 1917  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1st 1946 to 12/23 1946  
that I last saw her alive on 12/23 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of the uterus

Duration: 1 yr 6 mos

8. AGE:

Years	Months	Days	If less than one day
<u>34</u>	<u>4</u>	<u>12</u>	hr. <u>1</u> min.

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

9. Birthplace: St. Joseph, Mo  
(City, town, or county) (State or foreign country)

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation: Housewife

Major findings: \_\_\_\_\_  
Of operations: 48 B

11. Industry or business: None

Of autopsy: \_\_\_\_\_

12. Name: Thomas Collins

PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

14. Maiden name: Thomas Collins

15. Birthplace: St. Joseph, Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant: Thomas Collins

(b) Address: 913 E 14th St

17. (a) Burial (b) Date thereof: Jan. 13, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Kirksville, Missouri

18. (a) Signature of funeral director: Horace W. Sweeney

(b) Address: 1802 Union St. St. Joseph, Mo.

19. (a) 1-11-47 (b) L. B. Jenkins  
(Date received local registrar) (Registrar's signature)

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: G. E. Grooms M.D. (Physician or other)

Address: State Hospital #17 Date signed: 12/23/46

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

42199

**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,

*Ernest Thomas*

Licensed Embalmer No.

*2640*

P. O. Address,

*St. Joseph, 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.**