

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

Registration District No. 318 Primary Registration District No. 1003

**1. PLACE OF DEATH:**

(a) County.....  
 (b) City or town..... St. Louis,  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5470 Clemens Ave.,  
 (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)

**3: (a) PRINT FULL NAME** EDNA W. LIPPINCOTT.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife..... Isaac Lippincott. 6. (c) Age of husband or wife if alive. 70. years

7. Birth date of deceased. February 1, 1878.  
 (Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>70.</u>	<u>4.</u>	<u>14.</u>	hr. min.

9. Birthplace St. Louis, Missouri.  
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home.

**MOTHER FATHER**

11. Industry or business.....

12. Name John Wright.

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

14. Maiden name Mae McManus.

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

16. (a) Informant Isaac Lippincott.  
 (b) Address 5470 Clemens Ave.,

17. (a) Interment. (b) Date thereof 6/17/48.  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery.

18. (a) Signature of funeral director. C.R. Lupton & Sons.  
 (b) Address 7233 Delmar Blvd.

19. (a) JUN 17 1948 (b) J. F. Bredeck  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 600 17 9 0

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

(d) Street No. 5470 Clemens Ave.,  
 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
 If yes, name country.....

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month June day 15  
 year 1948 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from Feb 19, 1944 to June 15, 1948  
 that I last saw her alive on June 15, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myelogenous leukemia Duration 3 yrs

Due to.....

Due to..... 74

Other conditions (Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
 Of operations.....  
 Of autopsy.....

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 Helen B. Day (M. D. or other)  
 Address 3720 Washington Date signed 6-17-48

1-5 (except Med.)

**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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**