

No. 309
10-47
5-17-39
I 3906

FILED SEP 7 1948
Registration District No. **217**

Primary Registration District No. **3068**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **MAPLEWOOD**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7125 SOUTH ST.
(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 **PETER PAUL KIPPING**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **SOLIA NOSEL**

6. (c) Age of husband or wife if alive **79** years

7. Birth date of deceased **AUGUST 29, 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

82 11 20 hr. min.

9. Birthplace **HELDORF GERMANY**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED**

11. Industry or business _____

MOTHER FATHER

12. Name **FREDERICK KIPPING**

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

14. Maiden name **MARY ANN KIPPING**

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

16. (a) Informant **MRS. SOLIA KIPPING**

(b) Address **7125 SOUTH ST.**

17. (a) **BURIAL** (b) Date thereof **8-21-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEIREF, MO.**

18. (a) Signature of funeral director **M. J. Grayhan**

(b) Address **7146 MANCHESTER**

19. (a) **AUG 20, 1948** (b) **Carl A. Z. Sharp, M.D.**
(Date received local registrar) (Registrar's signature) (C.H.)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **St. Louis**

(c) City or town **MAPLEWOOD**
(If outside city or town limits, write "RURAL")

(d) Street No. **7125 SOUTH ST.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **1974**
year **1948** hour **2** minute **30 AM**

21. I hereby certify that I attended the deceased from **Jan 1 - 48**
Aug 20, 19**48** to **Aug 18**, 19**48**

that I last saw him alive on **Aug 18**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of prostate gland with metastasis in old viscera**

Duration **8 wks**

Due to **IB**

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)

(a) Means of injury _____

23. Signature **W. A. Walters M.D.** (M. D. or other) **W. A. Walters**
Address **3608 D. Grand** Date signed **8/20/48**

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: *W. W. Wilkins*

Licensed Embalmer No. *3575*

P. O. Address *St Louis, 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.