

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

30075

State File No. \_\_\_\_\_

FILED OCT 13 1948  
Registration District No. 18

Primary Registration District No. 55-79

Registrar's No. 179

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural - In-C-A - Bartlett  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Lake Tapawingo  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none  
(Specify whether years, months or days)

In this community 51 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

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

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

3. (a) PRINT FULL NAME Emma Jane Ripple

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Abraham L. Ripple 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased July 4 1868  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29  
year 1948 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 9-27-48  
2, 1948, to 9-29-48, 1948;  
that I last saw her alive on 9-29-48, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary occlusion Duration 48 hrs.

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>2</u>	<u>25</u>	hr. _____ min.

Due to Coronary sclerosis

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

10. Usual occupation at home

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

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

11. Industry or business \_\_\_\_\_

12. Name No Record

13. Birthplace No Record  
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 9/30

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. H. F. Higgins

(b) Address 6100 Floyd, Merriam, Kans.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/48  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cem.

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? \_\_\_\_\_

18. (a) Signature of funeral director Gates Funeral Home

(b) Address Kansas City Kansas

19. (a) 9-30-48 (Date received local registrar) (b) Donald C. Earnshaw  
(Registrar's signature)

23. Signature J. E. Avery (M. D. or other) D.O.

Address Blue Springs, Mo. Date signed 9-30-48

W. A. Owen  
Bine Springs, Mo

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**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

*Jimmy S. Hucks*

Licensed Embalmer No. *4092*

P. O. Address

*Missouri, Kan*

**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.**