

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1949

State File No. 1385
Registrar's No. 74

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 57 yrs.			
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1705 East 12th Street	

3. NAME OF DECEASED (Type or Print) a. (First) IRENE b. (Middle) c. (Last) PIPES	4. DATE OF DEATH (Month) (Day) (Year) JANUARY 3 1949
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5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JANUARY 1 1889	9. AGE (In years last birthday) 60	10. UNDER 1 YEAR Months	10. UNDER 24 HRS. Days	10. UNDER 24 HRS. Hours	10. UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) SPRINGFIELD, MISSOURI	12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME THOMAS BEAN	13b. MOTHER'S MAIDEN NAME PRISCILLA HIGGS	14. NAME OF HUSBAND OR WIFE JERRY PIPES
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME HUSBAND: JERRY PIPES	ADDRESS 1705 E. 12th Street
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC DELATATION		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4/34.5		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 0
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22. I hereby certify that I attended the deceased from 12/29, 1948, to 1/3, 1949, that I last saw the deceased alive on 1/3/49, 19 , and that death occurred at 6:45P m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis (Degree or title)	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 1/5/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-8-49	24c. NAME OF CEMETERY OR CREMATORY Lincoln Cern.	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 1-7-49	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE E. Sterling Bills	ADDRESS 1212 1/2 Ave. No.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 7

FEB 1 1949

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

E. Sterling Bills

Signed.....
Student Embalmer

Licensed Embalmer No. *3178*

P. O. Address, *1212 Vine St.*

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.