S. No. 300
V. 10.48

933

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

FILED MAY 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13507

State File No.

BIRTH NO. REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6064 Registrar's No. 21

1. PLACE OF DEATH
a. COUNTY St. Clair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osceola (Rural)
c. LENGTH OF STAY (In this place) 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Buchanan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dekalb
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Russell
b. (Middle) Lee
c. (Last) Pippin

4. DATE OF DEATH (Month) (Day) (Year) Apr; 10-49

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May; 3, 1888
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE ----

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.
17. INFORMANT'S SIGNATURE OR NAME Margie Pippin
ADDRESS Osceola Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Found dead in bed. No signs of violence. Probably conorary thrombosis.

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.

INTERVAL BETWEEN ONSET AND DEATH

4201

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 10:A *m., from the causes and on the date stated above.*

23a. SIGNATURE T. B. Goodrich
(Degree or title) Coroner
23b. ADDRESS Osceola Missouri
23c. DATE SIGNED 4-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4-12-49
24c. NAME OF CEMETERY OR CREMATORY Osceola
24d. LOCATION (City, town, or county) (State) Osceola Missouri

DATE REC'D BY LOCAL REG. 4-11-1949
REGISTRAR'S SIGNATURE Ruth Leeper
25. FUNERAL DIRECTOR'S SIGNATURE T B Goodrich
ADDRESS Osceola Mo

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 4-49-483
Date Filed 5-5-49

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 _____
Student Embalmer

Signed J B Goodrich
Licensed Embalmer No. 3038
P. O. Address Oneonta, N.Y.

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.