

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25295**
Registrar's No. **6429**

FILED JUL 30 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY 000	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 24 yrs	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION FRISCO Hospital		d. STREET ADDRESS (If rural, give location) 23 - 1776th Mississippi Ave	
3. NAME OF DECEASED (Type or Print) a. (First) CARL b. (Middle) C. c. (Last) Sipes		4. DATE OF DEATH (Month) (Day) (Year) July 24 1949	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Sept. 19-1900
9. AGE (In years last birthday) 48		10. MONTHS 10	11. DAYS 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		10b. KIND OF BUSINESS OR INDUSTRY Ry. Exp. Co.	
11. BIRTHPLACE (State or foreign country) Oskeola, Iowa		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME FRANK Sipes		13b. MOTHER'S MAIDEN NAME ELIZA SPARGEN	
14. NAME OF HUSBAND OR WIFE ROSA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NIL		16. SOCIAL SECURITY NO. 489-20-2728	
17. INFORMANT'S SIGNATURE OR NAME ROSA SIPES		ADDRESS - 1776th Mississippi	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephritis, Chr. INTERVAL BETWEEN ONSET AND DEATH 3-6 mo 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. Hypertension (Related) Myocarditis		9 mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) 131			
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? 592X			
22. I hereby certify that I attended the deceased from Apr. 27, 1949 , to July 24, 1949 , that I last saw the deceased alive on July 23, 1949 , and that death occurred at 6:00 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Kenneth Miller		23b. ADDRESS 4960 Laclede	
23c. DATE SIGNED 7-24-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-27-49	
24c. NAME OF CEMETERY OR CREMATORY Mount Hope		24d. LOCATION (City, town, or county) (State) St. Louis County - Mo	
DATE REC'D BY LOCAL REG. JUL 25 1949		REGISTRAR'S SIGNATURE J. B. Sasator	
FUNERAL DIRECTOR'S SIGNATURE Allen W McLaughlin		ADDRESS 2301 Lafayette	

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.

Student
Student Embalmer

Signed

R. P. Cooper

Licensed Embalmer No. 3633

P. O. Address 2301 N. Myrtle

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.