

FILED AUG 8 1949

THE REPUBLIC OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25861

BIRTH NO. _____		REG. DIST. NO. 353		PRIMARY REG. DIST. NO. 6196		Registrar's No. 19	
1. PLACE OF DEATH a. COUNTY Texas				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY Dent			
b. CITY (If outside corporate limits, write RURAL and give township) Licking 3		c. LENGTH OF STAY (in this place) day or so		c. CITY (If outside corporate limits, write RURAL and give township) Rural Watkins 3			
d. FULL NAME OF HOSPITAL OR INSTITUTION x				d. STREET ADDRESS (If rural, give location) West of Salem Mo 1			
3. NAME OF DECEASED (Type or Print), Alice Stax Sarah Tripplett		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH 7/16/49		5. SEX female		6. COLOR OR RACE w		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	
8. DATE OF BIRTH Dec 13 1870		9. AGE (In years last birthday) 78		10. MONTHS 3		11. UNDER 1 YEAR 3	
12. UNDER 2 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY x		11. BIRTHPLACE (State or foreign country) Dent Co Mo	
12. CITIZEN OF WHAT COUNTRY? U S		13a. FATHER'S NAME Robert Shelton		13b. MOTHER'S MAIDEN NAME Sally Skeeters		14. NAME OF HUSBAND OR WIFE Joel Tripplett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Myrtle Robnett Salem 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbidity 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. 4201					
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to July 13, 1949, that I last saw the deceased alive on July 13, 1949, and that death occurred at 9 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Lester Randall M.D. Licking Mo.				23b. ADDRESS		23c. DATE SIGNED 7/17/49	
24a. BURIAL CREMATION, REMOVAL (Specify) burial		24b. DATE 7/18/49		24c. NAME OF CEMETERY OR CREMATORY Berry		24d. LOCATION (City, town, or county) (State) Jov Mo	
DATE REC'D BY LOCAL REG. July 29, 1949		REGISTRAR'S SIGNATURE Mrs. Elvora Hester 324		25. FUNERAL DIRECTOR'S SIGNATURE Carl H. Jones		ADDRESS Salem Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

Revised
8-1-4
10:30 AM

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed Carl H. Jones

Licensed Embalmer No. 9370

P. O. Address Salinas, 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.