

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28236

State File No. 7323

100621

318

1003

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|---|--|--|--|---|--|--|--|
| BIRTH NO. 100621 | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 7323 | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Missouri.) | | | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 17 | | | |
| c. LENGTH OF STAY (in this place) 6 DAYS | | | | d. STREET ADDRESS (If rural, give location) 1519 GRAYE Grape 9 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1. | | | | 4. DATE OF DEATH (Month) (Day) (Year) August 21st, 1949 | | | |
| 3. NAME OF DECEASED (Type or Print) LINDA | | a. (First) | | b. (Middle) SUE D | | c. (Last) KIPP | |
| 5. SEX FEMALE | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | | 8. DATE OF BIRTH April 19 1943 | |
| 9. AGE (In years last birthday) 6 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | 11. BIRTHPLACE (State or foreign country) ST. LOUIS D | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME Fred KIPP | | 13b. MOTHER'S MAIDEN NAME Beatrice HAWN | | 14. NAME OF HUSBAND OR WIFE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME Fred Kipp ADDRESS 1519 GRAYE | | | |
| 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) Poliomyelitis & Polioencephalitis bulbospina 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. | | | | | |
| 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) 34 | | | |
| 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? 0800 | | | |
| 22. I hereby certify that I attended the deceased from 8/15/49, 19 to 8/21/49, 19, that I last saw the deceased alive on 8/21/49, and that death occurred at 3:10am, from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Joseph J. Mueller, M.D. | | | | 23b. ADDRESS 1515 Lafayette Ave., | | 23c. DATE SIGNED 8/21/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE AUG 24 49 | | 24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK | | 24d. LOCATION (City, town, or county) (State) St. Louis, MO. | |
| DATE REC'D BY LOCAL REG. AUG 23 1949 | | REGISTRAR'S SIGNATURE J. B. Fasater | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. H. Kelly 4386 Lindell | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

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 James A. Lemmers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.