

No. 300
10-48

FILED JUN 26 1953
XC 1172 85 56
REG# 109536

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23439**

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 506 Registrar's No. 1617

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON BARRACKS, MO.		c. LENGTH OF STAY (In this place) 75 DAYS	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS (If rural, give location) 3645 Laclede Ave. 2549	

3. NAME OF DECEASED (Type or Print) a. (First) Bobbie b. (Middle) A. c. (Last) CRIPPS	4. DATE OF DEATH (Month) (Day) (Year) 6-10-53
---------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9-17-27	9. AGE (In years last birthday) 25	IF UNDER 1 YEAR Months _____	IF UNDER 14 Hrs. Hours _____	IF UNDER 1 Min. Min. _____
--------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------	-------------------------------------------	------------------------------	------------------------------	----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTALLER	10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY? USA
--------------------------------------------------------------------------------------------------------------	----------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME RICHARD CRIPPS	13b. MOTHER'S MAIDEN NAME LULA CHAPMAN	14. NAME OF HUSBAND OR WIFE JUANITA CRIPPS
------------------------------------------	-----------------------------------------------	---------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II	16. SOCIAL SECURITY NO. 493-28-0357	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF BRKS, MO.	ADDRESS _____
---------------------------------------------------------------------------------------------------------------------------	--------------------------------------------	------------------------------------------------------------------------------	---------------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PERIARTERITIS NODOSA		
	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 HYPERTENSIVE CARDIO-VASCULAR DISEASE Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 456X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____
------------------------------------------------	------------------------------------------------------------------------------------------------	-------------------------------------------------------

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 3-27, 1953, to 6-10, 1953, and that death occurred at 1:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE Milton H. Lincoff (Degree or title) M.D.	23b. ADDRESS VET ADM HOSP., JEFF BRKS, MO.	23c. DATE SIGNED 6-10-53
-----------------------------------------------------------------------	---------------------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-12-53	24c. NAME OF CEMETERY OR CREMATORY St. Matthews	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---------------------------------------------------------	--------------------------	--------------------------------------------------------	---------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 6-11-53	REGISTRAR'S SIGNATURE Herbert R. Daniels	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
-----------------------------------------	-------------------------------------------------	---------------------------------------------------------	--------------------------------------

(Signed 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
Signature of Student Embalmer

Signed
John S. Demush

Licensed Embalmer No. 419

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.