

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6674

State File No.

BIRTH NO. FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1249

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Festus</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	<u>LEWIS</u>	<u>L.</u>	<u>PIPPIN</u>	<u>February 4, 1954</u>

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>5-7-1874</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Lewis Pippin</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Dollie Pippin</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dollie Pippin, Festus, Mo.</u>

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident</u>		<u>several min.</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c)		<u>many yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Questionable intra-abdominal neoplasm</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>331X</u>

22. I hereby certify that I attended the deceased from 1-6-, 1954, to 2-4-, 1954, that I last saw the deceased alive on 2-4-, 1954, and that death occurred at 4:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. J. Venillian, M.D.</u>	23b. ADDRESS <u>BARNES HOSPITAL</u>	23c. DATE SIGNED <u>2-4-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>2-5-54</u>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <u>Crystal City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>FEB 9 1954</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Politte F.H., Crystal City, Mo.</u>
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S.P. (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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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.