

FILED JUN 7 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18227

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 4982

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>13 days</b>		c. CITY OR TOWN <b>DuQuoin</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>8120</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>Petersen</b> c. (Last) <b>Lipe</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 22, 1956</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Sept. 16, 1889</b>		9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Elkville, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Elsworth Lipe</b>		13b. MOTHER'S MAIDEN NAME <b>Almira Kimmel</b>		14. NAME OF HUSBAND OR WIFE <b>Pearl Lipe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W W I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Clyde J. Lipe, 5067 Washington</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute postoperative anuria.</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Acclusion of left renal artery.</b> <b>6 days (est.)</b> DUE TO (c) <b>Generalized arteriosclerosis with aneurysm of abdominal aorta - rupt.</b>  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 checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>451x</b>	
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 <b>5/10</b> , 19 <b>56</b> , to <b>5/22/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/21/56</b> , 19 <b>56</b> , and that death occurred at <b>2:00 A. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>C. Pauling Haulan M.D.</b>				23b. ADDRESS <b>Desloge Hospital</b>		23c. DATE SIGNED <b>5-23-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>5-22-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Elkville, Ill.</b>		
DATE REC'D BY LOCAL REG. <b>MAY 23 1956</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

09661 11 7007

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 *G. W. Wilkinson*

Licensed Embalmer No. *35*

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