

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23129

State File No.

FILED AUG 13 1956

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 62

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| 1. PLACE OF DEATH a. COUNTY Clay | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay | |
| b. CITY (If outside corporate limits, write RURAL and give town) Excelsior Springs | c. LENGTH OF STAY (If in place) 34 yrs | c. CITY OR TOWN Excelsior Spgs | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 120 Sycamore Street | | STREET ADDRESS (If rural, give location) 120 Sycamore Street 60020 | |

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|---------------------------------------------------------|------------|-------------|-----------------------|--------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) KATHERINE | a. (First) | b. (Middle) | c. (Last) LIPP | 4. DATE OF DEATH (Month) (Day) (Year) July 16 1956 |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH April 27 1852 | 9. AGE (In years last birthday) 104 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hour | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and State or Foreign Country) Butler Penn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |

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| 13a. FATHER'S NAME Peter Meyer | 13b. MOTHER'S MAIDEN NAME Barbara Smith | 14. NAME OF HUSBAND OR WIFE ##### |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Bertha Strayer-Excelsior Spgs Mo |
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| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction | | INTERVAL BETWEEN ONSET AND DEATH sev. days |
| | 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 Conditions contributing to the death but not related to the disease or condition causing death. Infermitie gaze | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 4201 | 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) |
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| 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? |
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22. I hereby certify that I attended the deceased from **Nov. 10 19 54** to **July 16 19 56**, that I last saw the deceased alive on **July 15, 1956**, and that death occurred at **6:05 A.M.** from the causes and on the date stated above.

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| 23a. SIGNATURE S. R. McCracken (Degree or title) M:D: | 23b. ADDRESS Excelsior Springs, Mo | 23c. DATE SIGNED 7/16/1956 |
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|----------------------------------------------------------|-------------------------------|---------------------------------------------------|-----------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE July 18 1956 | 24c. NAME OF CEMETERY OR CREMATORY Dubuque | 24d. LOCATION (City, town, or county) (State) Iowa |
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| DATE REC'D BY LOCAL REG. 7/18/56 | REGISTRAR'S SIGNATURE Baroline Hutchings | 25. FUNERAL DIRECTOR'S SIGNATURE Virgil Hope ADDRESS Excelsior Spgs Mo. |
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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, ~~by~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *James A. Mole*

Licensed Embalmer No. 329

P. O. Address **Excelsior S**

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.