

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 982

1445-57 FILED JAN 14 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hosp.		Length of stay in 1b 1 Hr.	d. STREET ADDRESS 940 E. University		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES COTNER LIPSCOMB			4. DATE OF DEATH Month Jan. Day 6 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6 1957	9. AGE (In years last birthday) IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours 1 Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) Springfield, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Forrest Lipscomb Jr.			14. MOTHER'S MAIDEN NAME Margaret Hobbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address Forrest Lipscomb Jr. Spfld, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atelectasis DUE TO (b) Extreme Prematurity DUE TO (c) 7625 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Just. Mulhroves 6 wks. Twin Pregnancy					INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr	
MEDICAL CERTIFICATION	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Hour — Month, Day, Year a. m. — p. m. —	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —	20f. CITY, TOWN, OR LOCATION —	COUNTY —	STATE —	
21. I attended the deceased from 2:50 PM to 3:30 PM and last saw her/him alive on 1-6-57 Death occurred at 3:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) H. Conrad M.D.			22b. ADDRESS 202 Prop. Bldg Springfield, Mo.		22c. DATE SIGNED 1-7-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/8/57	23c. NAME OF CEMETERY OR CREMATORY White Chapel	23d. LOCATION (City, town, or county) (State) Springfield, Mo.			
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 1-7-57	26. REGISTRAR'S SIGNATURE James Williamson		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 not embalmed 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**. (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.