

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37080

STATE FILE NUMBER

FILED NOV 14 1957

Registration District No. 314 Primary Registration District No. 3060 Registrar's No. 339

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Farmington,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Farmington,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Whiteway Nursing Home</u> Length of stay in 1b		d. STREET ADDRESS <u>508 N. Washington</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Hipes</u> First Middle Last		4. DATE OF DEATH <u>October 24 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1870</u>
9. AGE (In years and birthday) <u>87</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter B. Hipes</u>		14. MOTHER'S MAIDEN NAME <u>Martha Parker</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>None</u>	
		17. INFORMANT <u>Mrs. Charles Ward, Bonne Terre, Mo.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>4500</u>	
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 <u>Hour Month, Day, Year</u> 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 <u>1951</u> to <u>Dec. 1956</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Dec. 1956</u> Death occurred at <u>9:45</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Jack W. Miller M.D.</u> (Degree or title)		22b. ADDRESS <u>Bonne Terre, Mo.</u>	
		22c. DATE SIGNED <u>10/29/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/27/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hwy. 67, Bonne Terre, MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Sparks Funeral Home Bonne Terre, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 29, 1957</u>	
		26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Everett Sparrow*

Licensed Embalmer No. *42*

P. O. Address *Donny Te...*  
*Mo*

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.