

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001378

STATE FILE NUMBER

342

FEB 5 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 342

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CRESTWOOD MED. CENTER		Length of stay in lb 11 YEARS	d. STREET ADDRESS (If outside, give location) 5329 WAYNE AVENUE
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE J. KIPP			4. DATE OF DEATH Month Day Year JAN. 19. 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 24. 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) WILLIS, KANSAS
13a. FATHER'S NAME JOSEPH W. KIPP		13b. MOTHER'S MAIDEN NAME LORETTA HANNAH	14. NAME OF HUSBAND OR WIFE MRS. PEARL KIPP
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. NONE	17. INFORMANT JOE C. KIPP Address 6614 WEST 66TH ST. OVERLAND PARK, KANSAS
18. CAUSE OF DEATH (Only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) age - intractable asthma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 <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 1950 to 1-19-59 and last saw her alive on 1-17-59 Death occurred at 7-19-59 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George V. Feist MD		22b. ADDRESS 702 Professional B.	22c. DATE SIGNED 1-19-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN. 19. 1959	23c. NAME OF CEMETERY OR CREMATORY -	23d. LOCATION (City, town, or county) (State) HORTON KANSAS
24. FUNERAL DIRECTOR DIN. NEWCOMB'S SONS ADDRESS 1331. DRUSH CREEK KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 1-19-59	26. REGISTRAR'S SIGNATURE new minshall

George V. Feist USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

All diseases in Part I must be causally related.

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 *Basil Honey*

Licensed Embalmer No. *4724*

P. O. Address *A.P. 30, 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.