

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014586

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 316 Primary Registration District No. Registrar's No. 163

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cardleton</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Elvins Rt 1</b> <b>0940</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <b>9 mos</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Jean Esther Chipman</b>			4. DATE OF DEATH Month Day Year <b>April 23, 1959</b>		
--	--	--	---	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 16, 1913</b>	9. AGE (In years last birthday) <b>46</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	--	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Moorehouse, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
---	--	-----------------------------------	---	--

13a. FATHER'S NAME <b>Robert E. Southard</b>		13b. MOTHER'S MAIDEN NAME <b>Lillie England</b>	14. NAME OF HUSBAND OR WIFE <b>Beecher Chipman</b>	
---	--	--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Giniver Shockley St. Louis, Missouri</b>	
--	-------------------------	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>accidental drowning</b>			INTERVAL BETWEEN ONSET AND DEATH <b>9298</b> <b>42</b>
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)			

20a. ACCIDENT <input checked="" 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.) <b>Fell in lake while fishing</b>
--	--	---

20c. TIME OF INJURY Hour Month, Day, Year <b>6 p.m. 4/23/59</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, pdg., etc.) <b>farm lake</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Cardleton Twp. St. Francois, Mo.</b> <b>094</b>
---	--	---	--	---

21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Beil Miller</b>		22b. ADDRESS <b>Farlington, Mo</b>	22c. DATE SIGNED <b>4/24/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/27/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>IOOF Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Doe Run, Mo.</b>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <b>Miller Funeral Home Farlington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Apr. 27, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Esther Redloff</b>
--	--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

ASEI 9 April

MAY 6 1959

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 Paul H. Dugal

Licensed Embalmer No. 4120

P. O. Address Farmington, 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.