

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022559
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 309 Primary Registration District No. 6040 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY St Charles			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Charles		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Portage Des Sioux		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Portage Des Sioux		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Portage Des Sioux 33 yrs		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Rural Rt 1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Herbert Middle W Last Kipp			4. DATE OF DEATH Month June Day 12 Year 1959		
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 Sept. 27 1925	9. AGE (In years of birthday) 33	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St Charles County Mo		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Hugo Kipp		13b. MOTHER'S MAIDEN NAME Chirstina Anderson		14. NAME OF HUSBAND OR WIFE None	
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 Address Hugo Kipp Portage Des Sioux 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) Broncho Pneumonia					INTERVAL BETWEEN ONSET AND DEATH 3 days
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) Spastic Paraplegia, Epilepsy					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 491X			
20c. TIME OF INJURY Hour _____ 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 March (9-55) to June 12-59 and last saw him alive on June 11-59 Death occurred at 10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Vincent A. Schuber MD			22b. ADDRESS St Charles, Mo		22c. DATE SIGNED 6/15/59.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/15/59	23c. NAME OF CEMETERY OR CREMATORY Orchard Farm Cemetery		23d. LOCATION (City, town, or county) (State) Orchard Farm Mo	
24. FUNERAL DIRECTOR ADDRESS Arthur C Baue St Charles Mo.			25. DATE RECD. BY LOCAL REG. June 18 1959	26. REGISTRAR'S SIGNATURE W.H. Gasser	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

SEP 2 1950

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 *Arthur C. Bane*

Licensed Embalmer No. *3154*

P. O. Address *St. Charles*

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.