

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029556

FILED VS AUG 20 1959

Registration District No. 166 Primary Registration District No. 3029 Registrar's No. 120

STATE FILE NUMBER

| | | | | | | | |
|--|---|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Jefferson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ste. Genevieve</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Crystal City</u> | | Length of stay in lb <u>6 months</u> | | c. CITY OR TOWN <u>Ste. Genevieve</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>1110 Taylor</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Main Street</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Pauline Amelia Hipes</u> | | | | 4. DATE OF DEATH Month Day Year <u>Aug. 9, 1959</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>28 Sept 1875</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | | 11. BIRTHPLACE (City and state or country) <u>Ste. Genevieve, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>Charles Buehler</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Pauline Graff</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Peter Hipes</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 Address <u>Mrs. Iona Kemp, 1110 Taylor, Crystal City, Mo</u> | | |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis abdominal and common iliac arteries (so-called "saddle-block thrombus")</u> DUE TO (b) <u>Generalized arteriosclerosis and arteriosclerotic heart disease.</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 yrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1) History of two recent strokes (cerebral thrombosis)?</u> <u>2) Moderate essential hypertension.</u> | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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"/> <u>None</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>---</u> | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>none</u> | | 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.) <u>---</u> | | | 20f. CITY, TOWN, OR LOCATION <u>---</u> | | COUNTY STATE | | |
| 21. I attended the deceased from <u>I-27-1956</u> , to <u>8-9-1959</u> and last saw her ^{her} him alive on <u>8-9-1959</u> Death occurred at <u>7:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>John F. Rutenge M.D.</u> | | | | 22b. ADDRESS <u>Crystal City, Mo.</u> | | | 22c. DATE SIGNED <u>8-11-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>12 Aug., 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u> | | 23d. LOCATION (City, town, or county) (State) <u>Ste. Genevieve, Mo.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Jeffry Stanton, Ste. Genevieve, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>8-11-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Paul G. Pison</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 18 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald H. Vining

Licensed Embalmer No. 34608

P. O. Address Pestana

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.