

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037815**

**FILED VS. NOV 3 1959**

Primary Registration District No.

Registrar's No. **2 9802**

STATE FILE NUMBER

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Lo</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5470 Clemens St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Dr. Isaac</b> Middle <b>Lippincott</b> Last			<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>26</b> Year <b>1959</b>		
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5/20/1873</b>	<b>9. AGE (last birthday)</b> <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Phd. Washington University (Retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>University (Retired)</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Villa Ridge, Ill.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>Daniel Perry Lippincott</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Wells</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Edna Wright Lippincott</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		<b>16. SOCIAL SECURITY NO.</b> <b>499-34-0574</b>	<b>17. INFORMANT</b> Address <b>Mr. Jack W. Lippincott 21 St. Alfred Rd.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>4200</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senile arteriolar nephrosclerosis</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <b>1954</b> to <b>10/26/59</b> and last saw <del>her</del> <b>him</b> alive on <b>10/25/59</b> Death occurred at <b>4:30a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22. SIGNATURE</b> (Degree or title) <i>Hugh R. Waters</i> <b>M.D.</b>			<b>22b. ADDRESS</b> <b>600 Union Blvd. St. Louis 8</b>		<b>22c. DATE SIGNED</b> <b>10/26/59</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>Oct. 28, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bellefontaine Cem.</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Missouri.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>C.R. Lupton and Sons 7233 Delmar Blvd.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 26 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Loan Smith</i> <b>M.D.</b> R.P.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.