

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041485

FILED VS DEC 15 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 459

ENDED

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 3Y; 8M; 20d	c. CITY OR TOWN Lebanon
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Oakland Star Route
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ARVIL Middle LESTER Last RIPPY	4. DATE OF DEATH Month Nov. Day 30 Year 1959
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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 Oct. 24, 1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months 1 Days 6	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming and dairy work	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Oakland, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.S.
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13a. FATHER'S NAME John Bunyan Rippey	13b. MOTHER'S MAIDEN NAME Minnie Lucity Wagoner	14. NAME OF HUSBAND OR WIFE
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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. 563-12-8950	17. INFORMANT Records, State Hospital No. 4, Farmington, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral thrombosis - - - - -		Abt. 2 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis - - - - -	Unknown
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Psychosis with cerebral arteriosclerosis.	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 	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.)	20f. CITY, TOWN, OR LOCATION 	COUNTY 	STATE
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21. I attended the deceased from Dec. 31, 1955 to Nov. 30, 1959 and last saw ^{XDE} him Nov. 30, 1959 Death occurred at 4:55 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>John A. Brennan, M.D.</i> (Degree or title)	22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 12-2-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-2-59	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION (City, town, or county) Oakland, Missouri	(State)
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24. FUNERAL DIRECTOR Hollan Funeral Home, Lebanon, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Dec. 3, 1959	26. REGISTRAR'S SIGNATURE <i>Ethel Redloff</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JAN 6 1960

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 Robert H. Dwyer

Licensed Embalmer No. 4120

P. O. Address Farmington

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.