

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

=60-030971

STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 176

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 1 week	c. CITY OR TOWN Sarcoxie Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) SAPHRONIA IPOCK	4. DATE OF DEATH August 18, 1960
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5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-29-74	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and state or country) Seymour, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME John Denny	13b. MOTHER'S MAIDEN NAME not available	14. NAME OF HUSBAND OR WIFE Joseph B. Ipock
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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. none	17. INFORMANT Address Sarcoxie Mo Mrs. Jewell Goodson, Rt 1, Mo
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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: IMMEDIATE CAUSE (a) Pedumony edema.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic congestive heart failure	unknown
	DUE TO (c) myocarditis - rheumatic	unknown.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) nephritis - chronic		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

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 3:35 a.m. p.m. pm Month, Day, Year 8-18-60	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 Carthage COUNTY Mo STATE Mo
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21. I attended the deceased from 8-17-60 to 8-18-60 and last saw her/him alive on 8-18-60 Death occurred at 3:35 pm on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE [Signature] (Degree or title) MD	22b. ADDRESS 1515 Hazel Ave, Carthage, Mo	22c. DATE SIGNED 8-19-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 8-22-60	23c. NAME OF CEMETERY OR CREMATORY Reeds Cemetery	23d. LOCATION (City, town, or county) (State) Reeds, Mo 60
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24. FUNERAL DIRECTOR Knell Mortuary, Carthage, Mo ADDRESS	25. DATE RECD. BY LOCAL REG. 8-20-60	26. REGISTRAR'S SIGNATURE [Signature]
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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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

-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.