

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Length of stay in 1b	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. ANTHONY'S Hosp.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>3230 IOWA</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>EDITH LIPE</i>			4. DATE OF DEATH Month Day Year <i>DEC. 26 1960</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>APR. 10 1887</i>	9. AGE (last birthday) <i>73</i>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U - S - A.</i>	
13a. FATHER'S NAME <i>HENRICH HOGE</i>		13b. MOTHER'S MAIDEN NAME <i>JULIA SCHONHAUSER</i>		14. NAME OF HUSBAND OR WIFE <i>HOMER LIPE</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>499-01-3438</i>		17. INFORMANT Address <i>HOMER LIPE 3230 IOWA</i>	

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) <i>Chronic Myocarditis with Failure</i>			<i>6 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Generalized Arteriosclerosis</i>		<i>indefinite</i>
	DUE TO (c) <i>422.1</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		

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
21. I attended the deceased from <i>December 24</i> to <i>December 26</i> and last saw her <i>him</i> alive on <i>Dec. 25 1960</i>		
Death occurred at <i>4:30 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <i>Nicholas A. Young MD</i>	22b. ADDRESS <i>4307.5 Grand Blvd</i>	22c. DATE SIGNED <i>Dec. 27, 1960</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>DEC. 28 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MEMORIAL PARK</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Thomas Lutes 2906 Gravis</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 27 1960</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i>
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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

Eleanore

Licensed Embalmer No. *340*

P. O. Address *2906*

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