

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

XC-14809670 SL 3589

2872-61-011694 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2872

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF CLEARED THROUGH CORONER'S SIGNATURE

1. PLACE OF DEATH APR 7 1961 a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY <i>St Louis</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS, MO.		Length of stay in lb 2 DAYS	c. CITY, OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS. ADMIN. HOSPT.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10117 W. FLORISSANT		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH RAYMOND TRIPP			4. DATE OF DEATH Month Day Year MARCH 25 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/30/96	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) AIRCRAFT TOOL PLANNER (RET)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) HELOIT, WISC.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME GEORGE TRIPP		13b. MOTHER'S MAIDEN NAME FANNIE STAUFFACHER		14. NAME OF HUSBAND OR WIFE CLARA TRIPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO.		17. INFORMANT CLARA TRIPP (WIDOW) SEE #2 Address	
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) PROBABLE HEART FAILURE					
DUE TO (b) DELIRIUM TREMENS					
DUE TO (c) FRACTURED LEFT FEMUR 904.0-21					2 DAYS
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>fell in home</i>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 3 23 61					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St Louis Co Mo</i>	
21. <input checked="" type="checkbox"/> attended the deceased from <i>VA</i> 3/23/61 to 3/25/61 and last saw him alive on 3/25/61		Death occurred at 6:50 p.m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) WALTER B. GOLDFARB M.D.			22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 3/28/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-29-61	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo
24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd. Ferg.		25. DATE RECD. BY LOCAL REG. MAR 27 1961		26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>	

MEDICAL CERTIFICATION

P.K. Paul Goldfarb Deputy Coroner 3/27/61

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 my self _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Reinhold K. Lehmann

Licensed Embalmer No. 3395
P. O. Address St Louis 35

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.