

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036074

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 365

STATE FILE NUMBER

AMENDED

FILED OCT 31 1961

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| 1. PLACE OF DEATH a. COUNTY BUTLER | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY RANDOLPH | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF | | Length of stay in 1b 207 Days | c. CITY OR TOWN POCAHONTAS Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION | | 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"/> |

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| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last NIPPS | 4. DATE OF DEATH Month OCTOBER Day 13 Year 1961 |
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| 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 11-23-93 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days | 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) FARMER | 10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE | 11. BIRTHPLACE (City and state or country) RANDOLPH COUNTY, ARK. | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME WILLIAM NIPPS | 13b. MOTHER'S MAIDEN NAME SARAH LOONEY | 14. NAME OF HUSBAND OR WIFE LILLIE NIPPS |
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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) YES WWI | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, 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) ENCEPHALOMALACIA | | INTERVAL BETWEEN ONSET AND DEATH One year | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) THROMBOSIS OF CEREBRAL ARTERIES | | Two years |
| | DUE TO (c) ARTERIOSCLEROSIS | | |
| 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 | |

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| 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 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 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 |
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| 21. I attended the deceased from March 20, 1961 to October 13, 1961 Death occurred at 8:35 AM on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN, M.D., Chief, Med. Svc. | 22b. ADDRESS VA Hospital, Poplar Bluff, Mo. | 22c. DATE SIGNED 10-17-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 10-14-1961 | 23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery | 23d. LOCATION (City, town, or county) (State) Pocahontas, Arkansas |
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| 24. FUNERAL DIRECTOR ADDRESS <i>McKabb</i> McKabb Funeral Home Arkansas | 25. DATE RECD. BY LOCAL REG. 10/25/1961 | 26. REGISTRAR'S SIGNATURE <i>Thomas G. ...</i> |
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

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 M. C. McNeill

Licensed Embalmer No. 680 (Ark.)

P. O. Address Joplin, 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.