

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Mo. Baptist San Registration District No. 791
Township St. Louis Primary Registration District No. 1003
City St. Louis (No. Mo. Bapt. San)

File No. 28636
Registered No. 8169
St. _____ Ward)

2. FULL NAME

Henry Gipsen
(a) Residence No. Hogarth Mo 12 Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel Gipsen
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. abt 36

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo
10. NAME OF FATHER Walter Gipsen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER May Skaggs
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

14.

INFORMANT Joe Huff
(Address) Hogarth Mo

15.

FILED SEP 11 1927
REGISTRAR May Estament

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-14-27
17. I HEREBY CERTIFY That I attended deceased from 9-14-27 to 9-14-27
that I last saw him alive on 9-14-27 at 11:30 a.m. and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute dilatation of heart during asystole
CONTRIBUTOR intercerebral obstructive strangulated hernia

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF 9-14-27
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) John D. [unclear], M. D.
(Address) Mo. [unclear]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Frontier Mo DATE OF BURIAL Sept 15 1927

20. UNDERTAKER

Phulander Craig ADDRESS 4768 Washington

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

