

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35303

State File No. _____

Registrar's No. 820

FILED NOV 12 1940
318

Registration District No. _____ Primary Registration District No. 2001

1. PLACE OF DEATH: GREENE

(a) County _____

(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Rippee, Mae Ollie

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Jim Rippee

6. (c) Age of husband or wife if alive See years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 56 (about) Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Hartsville, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Matron Mansfield High School

11. Industry or business _____

12. Name Mr. Ruben Young

18. Birthplace Wright, Mo.
(City, town or county) (State or foreign country)

14. Maiden name Sarah Stilles

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jim Young

(b) Address Hartsville, Mo.

17. (a) Burial (b) Date thereof Oct 9, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hartsville, Mo.

18. (a) Signature of funeral director Gene E. Hadden

(b) Address Hartsville, Mo.

19. (a) 10-9-40 (b) W. E. Haudley, MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town Mansfield
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1940 hour 4 minute _____ P. M.

21. I hereby certify that I attended the deceased from Oct 5, 1940, to Oct 6, 1940;
that I last saw her alive on Oct 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Perforated typhoid ulcer (Stem)

Due to _____

Due to Typhoid Fever

Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes

23. Signature W. E. Haudley, MD (M. D. or other) _____
Address Hartsville, Mo. Date signed Oct 7, 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

7