

FILED OCT 24 1944

Registration District No. 2

Primary Registration District No. 1000

Registrar's No. 1045

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Effie Jane Sipe

3. (b) If veteran, name war _____ 3. (c) Social Security No. No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Ira W. Sipe 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Sept 18 1892
(Month) (Day) (Year)

8. AGE: Years 52 Months 1 Days 1 If less than one day hr. _____ min. _____

9. Birthplace TERHAMA Nebr.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
12. Name Engene Leo Kelly
13. Birthplace Ontario Co. N. Y.
(City, town, or county) (State or foreign country)
14. Maiden name ANNA ELLA PARR
15. Birthplace MAHASKA IOWA
(City, town, or county) (State or foreign country)

16. (a) Informant Ira Wilson Sipe
(b) Address Bellefont R 2
17. (a) B (b) Date thereof 10-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellefont

18. (a) Signature of funeral director E. B. Brett
(b) Address Savannah Mo
19. (a) 10-20-44 (b) Thelma Gieble
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town near Wintersville
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1944 hour 2 minute 30 A M.

21. I hereby certify that I attended the deceased from 10-13-44
_____, 19____, to 10-19____, 19____
that I last saw h. a alive on 10-18____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia - lobar

Due to Operation for

Due to Cholecystitis

Other conditions 108
(Include pregnancy within 3 months of death)

Major findings: Cholecystitis
Of operations _____

Of autopsy None

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Paul Forgrar (M. D. or other)
Address St Joseph, Mo Date signed 10-20-44

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

NOV 28 1944

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.....

E. C. Breit

Licensed Embalmer No.....

2650

P. O. Address.....

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