

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9515

State File No.

BIRTH NO. _____ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3055 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Louisiana</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Cyrene</u>	
c. LENGTH OF STAY (In this place) <u>8 days</u>		d. STREET ADDRESS (If rural, give location) <u>No Street Address</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mineral Springs Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>Elizabeth</u>	c. (Last) <u>Sippely</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 16 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 12, 1909</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (State or foreign country) <u>Nodaway Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Walter Breit</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Carl Sippely</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Carl Sippely</u> ADDRESS <u>Cyrene Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Post-surgical shock</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>uterine fibroids unknown</u> DUE TO (c) <u>chronic alcoholism</u>		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>faty degeneration</u>			

19a. DATE OF OPERATION <u>Mar. 15</u>	19b. MAJOR FINDINGS OF OPERATION <u>uterine fibroids pyogenic salping</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Mar. 7th 1949, to Mar. 16th 1949, that I last saw the deceased alive on Mar. 16th 1949 and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)	23b. ADDRESS <u>Louisiana, Mo.</u>	23c. DATE SIGNED <u>Mar. 18, '49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/20/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>	24d. LOCATION (City, town, or county) (State) <u>Louisiana Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Mar. 19, 1949</u>	REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>GARNER & STERNE LOUISIANA MISSOURI</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

822

RECEIVED

District Health Officer No. 10

District File Number 3-49-52

Date Filed - MAR 25 1949

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.

Signed _____

Harold V. Garner

Signed _____
Student Embalmer

Licensed Embalmer No. 3720

P. O. Address Trinidad, N.J.

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, fact should be so stated above.