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FILED AUG 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25641**

BIRTH NO. _____ REG. DIST. NO. **217** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1200**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Jefferson Barracks, Mo.		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 6 days		d. STREET ADDRESS (If rural, give location) 9705 Riverview Drive	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vet. Adm. Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) A. c. (Last) GIPPERICH			4. DATE OF DEATH (Month) (Day) (Year) June 21 1949		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH June 19, 1886	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Postal Employee)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME William L. Gipperich		13b. MOTHER'S MAIDEN NAME Louise Zink		14. NAME OF HUSBAND OR WIFE -----			
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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 World-War		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Eugene F. Nolan, Registrar				ADDRESS Vet. Adm. Hosp. Jeff. Brks. Mo.	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH Unknown	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) INTRACRANIAL HEMORRHAGE							
		ANTECEDENT CAUSES DUE TO (b) Hypertension							
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION -----						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) St. Louis		(COUNTY) St. Louis		(STATE) Missouri	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 June 15, 1949, to June 21, 1949, that I last saw the deceased alive on June 21, 1949, and that death occurred at 11:00 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L.E. Stilwell, M.D. Chf. Prof. Services		23b. ADDRESS Vet. Adm. Hosp. Jeff. Brks. Mo.		23c. DATE SIGNED 6/22/49			
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/24/49		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetary		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
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DATE REC'D BY LOCAL REG. 6-21-49		REGISTRAR'S SIGNATURE Hertbert R. Dombey		25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral Und. Co.,						ADDRESS St. Louis, Mo.	
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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
Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 3534

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, fact should be so stated above.