

NOV 6 1943

Registration District No. 327

Primary Registration District No. 6111

Registrar's No. 327

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution:
Commerce, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 100

(a) State Missouri (b) County Scott

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Milton Leroy Tripp

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2nd
year 1943 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug. 1, 1943 to Sept 2, 1943
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Josephine Laffoon 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 17th 1857
(Month) (Day) (Year)

Immediate cause of death Uremia

Due to Chronic Brights Disease

Due to _____

Other conditions mitral regurgitation
(Include pregnancy within 3 months of death)

8. AGE: Years 80 Months 0 Days 15
If less than one day hr. _____ min.

Duration NR

Several Years

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace Quincy Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Milton Adam Tripp

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Adams

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

Major findings: Of operations 1318

Of autopsy _____

16. (a) Informant Mrs. Herman Koenemann

(b) Address Cape Girardeau, Missouri

17. (a) Burial (b) Date thereof 10-03-'43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McLains Chapel Cent.

18. (a) Signature of funeral director L. L. Heman

(b) Address Cape Girardeau, Missouri

19. (a) 10-20-43 (b) Mrs. Ida Hawkins
(Date received local registrar) (Registrar's signature)

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 F

23. Signature J. D. Ferguson (M. D. or other)
Address Benton Mo Date signed 10/4-43

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

1034

RECEIVED

District Health Office No. 2,

District File Number 1143-1373

Date Filed 11-3-43

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 Howard P. Haman

Licensed Embalmer No. 4122

P. O. Address Cape Girardeau, Missouri

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35942
Registrar's No. 327

Registration District No. 327

Primary Registration District No. 6111

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

1. PLACE OF DEATH:

(a) County Scott

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

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Milton Leroy Jupp

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 17 1906
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Year 1943 Hour minute M.

21. I hereby certify that I attended the deceased from , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above. Immediate cause of death

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

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?

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

23. Signature A. H. Ferguson (M. D. or other)

Address Date signed

SUPPLEMENTARY

35942