

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6258-58-047301
STATE FILE NUMBER

FILED JAN 30 1959

Registration District No. 370 Primary Registration District No. 6254 Registrar's No. 5

300
-57

1. PLACE OF DEATH a. COUNTY <u>WAYNE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WAYNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. FRANCIS</u>		c. CITY OR TOWN <u>1110</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 1/2 MILE. SILVA, MD.</u>		d. STREET ADDRESS (If outside, give location) <u>4 1/2 MILE. SILVA</u>	
Length of stay in 1b <u>28 yrs</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARTHA ELIZABETH</u> Middle <u>TRIPP</u> Last <u>TRIPP</u>			4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>58</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1 - 1867</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>ETHRIDGE, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>

13a. FATHER'S NAME <u>JOHN HENSON</u>		13b. MOTHER'S MAIDEN NAME <u>MARY F. EVANS</u>		14. NAME OF HUSBAND OR WIFE <u>ROBT. TRIPP</u>	
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 <u>VAN. B. TRIPP</u> Address <u>MALDEN, MD</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4211</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>0</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4211</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Dec 26-58</u> , to <u>12-31-58</u> and last saw her alive on <u>12-29-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>D.R. Fryer M.D.</u>		22b. ADDRESS <u>Caldwater, MD.</u>		22c. DATE SIGNED <u>1-10-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-2-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOUNDS CREEK</u>		23d. LOCATION (City, town, or county) (State) <u>SILVA. MO</u>	
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24. FUNERAL DIRECTOR <u>DAY & KNIGHT, F.H.</u> ADDRESS <u>MALDEN, MD</u>		25. DATE RECD. BY LOCAL REG. <u>1-27-59</u>		26. REGISTRAR'S SIGNATURE <u>Helta M. Ward</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *J. E. Shuman*

Licensed Embalmer No. *4086*

P. O. Address *Malden, MA*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.