S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26259

FILED AUG 5 1940

Registration District No. 784

Primary Registration District No. 2nd

Registrar's No. 1434

1. PLACE OF DEATH:

(a) County St Louis

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

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

(d) Length of stay: In hospital or institution 1025 Days (Specify whether)
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 2747 Russell
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

8. (a) PRINT FULL NAME William E. Hipes

8. (b) If veteran, name war No

8. (c) Social Security No. None

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Joyce Hipes

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 1 (Month) 18 (Day) 1861 (Year)

8. AGE: Years 79 | Months 0 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace St Genevieve Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

MOTHER FATHER

12. Name William Hipes

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

14. Maiden name Josephine Bichelt

15. Birthplace St Genevieve Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Koch Hospital Record

(b) Address Koch Hosp.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/40 (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Missouri

18. (a) Signature of funeral director C. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) JUL 31 1940 (Date received by local registrar) (b) R. Meyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 30
year 1940 hour 1 minute 40 A. M.

21. I hereby certify that I attended the deceased from July 1, 1939, to July 30, 1940, that I last saw him alive on 7/29, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 yrs.
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 Herbert F. Schwenk (M. D. or other) M.D.
Address Koch Hosp. Kochmo. Date signed 7/30/40

(Licensed Embalmer's Statement on Reverse Side)

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 Paul A. Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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