

N. B.—Every item on this form should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

33953

File No.

Registered No.

St. Ward

1. PLACE OF DEATH

County St. Francois

Township Randolph

City Elvins

Registration District No. 779

Primary Registration District No. 0024A

2. FULL NAME

(a) Residence. No. Peter Nipes St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan 1 - 1872

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

58

9

22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Genevieve Mo

(STATE OR COUNTRY)

mo

PARENTS

10. NAME OF FATHER

Peter Nipes

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Cooper Mo

(STATE OR COUNTRY)

Virginia

12. MAIDEN NAME OF MOTHER

Margaret Parker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

St. Genevieve Mo

(STATE OR COUNTRY)

mo

14.

INFORMANT

(Address)

John Nipes

Bonnetown Mo

15.

FILED

10-24-30

R. B. Dester

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

10/23 1930

17.

I HEREBY CERTIFY, That I attended deceased from

10/19

1930, to

10/18

1930

that I last saw him alive on 10/18, 1930, and that death occurred, on the date stated above, at 5:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

uriphritic heart

130

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF 1

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

clinical

(Signed) W. D. Dester, M. D.

10/24 1930 (Address) Elvins Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Bonnetown Mo

10-25 1930

20. UNDERTAKER

ADDRESS

McLaughlin Funeral Home

Geo. Bay and

STATE OF TEXAS, County of [redacted]
I, [redacted], a duly qualified and disinterested person, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of [redacted] State of Texas.
In testimony whereof, I have hereunto set my hand and the seal of said County at [redacted] this [redacted] day of [redacted] 19[redacted].

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Francis Registration District No. 779 File No.
Township Randolph Primary Registration District No. 6024a Registered No.
City (No., St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/23 1930

17.

I HEREBY CERTIFY That I attended deceased from 19, 19, 19
that I last saw h. alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute suppurative
gastroenteritis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

S-33953