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

Do not use this space.

17385

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4450

City St Louis, Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME John Tipton

(a) Residence. No. 1304 Chesnut St., 25 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 20 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)
male	Col.	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-8-1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60	1	24	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Gilmore Tipton

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT A. Gilmore Creath (Address) City Hospital

15. FILED 5 19 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-2- 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-18-, 1930, to 5-2-, 1930 that I last saw him alive on 5-2-, 1930 and that death occurred, on the date stated above, at 12:05 AM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

131

(duration) — yrs. 10 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 —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. E. Hale M. D.

5/3/1930 (Address) City Hospital #2

*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
Greenwood	5/6 1930
20. UNDERTAKER Richardson & Tyler	ADDRESS 1020 Brooklyn St

STATE OFMISSOURI,)
)SS.
City of St. Louis.)

Before me, a Notary Public, within and for the City of St. Louis, Mo., personally appeared Oka Taylor, to me known, and who makes oath and states that she is the daughter of John Tipton who died at City Hospital #2 on May 2, 1930, and that there is a mistake in age; that said John Tipton is 54 years of age having been born March 8, 1876 and not 60 years as appears on the recordsof said hospital.

Oka Taylor

Subscribed and sworn to before me this 12th day of May, 1930.

A. Gertrude Creath
Notary Public.
(Clerk) City Hospital #2

My commission expires July 25, 1933.

STATE OF MISSOURI)
)SS.
CITY OF ST. Louis.)

Before me, a Notary Public within and for the City of St. Louis, Mo., personally appeared Charles Tipton, who makes oath and states that he is the son of John Tipton who died at City Hospital #2 on May 2, 1930; and that when he brought his father into the hospital he gave his age as 60 years; that he was uncertain about his father's age and that he was mistaken about the same; that John Tipton is 54 years of age and not 60 as given by him.

Charles Tipton

Subscribed and sworn to before me this 12th day of May, 1930.

My term expires July 25, 1933.

A. Gertrude Creath
Notary Public.

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 ..... Registration District No. ..... File No. 4450

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME John J. Tipton

(a) Residence. No. 1303 Chouteau 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)
M	col.	Sin

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3 - 8 - 1876

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	54	1	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) .....

PARENTS
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 A. Gerhide Crouch
(Address) City Hospital

15. FILED ....., 19..... Hayden Porter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5 - 2 1930

17. I HEREBY CERTIFY, That I attended deceased from 4 - 8 1930, to 5 - 2 -, 19 30 that I last saw h..... alive on 5 - 2 -, 19 30, and that death occurred, on the date stated above, at 12:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

(duration) ..... yrs. 10 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 .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. C. Hale, M. D
, 19 (Address) City Hospital #2

*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 Richardson & Tyler
ADDRESS 1920 Broadway

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW