

Registration District No. 145

Primary Registration District No. 5208

Registrar's No. 4

1. PLACE OF DEATH: Carter Jct. Mo. Hwy 1  
 (a) County Carter  
 (b) City or town Highway 25 Rural  
 (c) Name of hospital or institution: at home  
 (If not in hospital or institution, write street number or location) 2  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 20 years  
 years, months or days 0 0 0

3. (a) PRINT FULL NAME Alice Tipton  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. ✓

4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Aron Tipton  
 6. (c) Age of husband or wife if alive 16 years  
 7. Birth date of deceased March 16 1903  
 (Month) (Day) (Year)

8. AGE: Years 36 Months 10 Days 21  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Henry Jones  
 13. Birthplace unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Jones  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Aron Tipton

(b) Address Grandin Mo.

17. (a) Burial (b) Date thereof 2-8-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Good Hope Cemetery

18. (a) Signature of funeral director family  
 (b) Address \_\_\_\_\_

19. (a) 3-25-1940 (b) Loyal B. Wood  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Carter  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 0 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7  
 year 1940 hour 4: minute 00 A. M.  
 21. I hereby certify that I attended the deceased from Feb. 6 1940 to Feb. 7 1940  
 that I last saw her alive on Feb. 6 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 2 days  
 Due to Chronic Bronchitis  
 Due to Tuberculosis  
 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 Wm. H. Burton (M. D. or other) 1  
 Address Van Buren Date signed 2-7-40

PLEASE PRINT IN BLACK INK—MAKE A PERMANENT RECORD

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.

I class

105

---

**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.

**RECEIVED**  
District Health Officer No. 5,  
District File Number. 4460 453  
Date Filed 11/14/0

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 105-78

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 145

Primary Registration District No. 5208

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Carter  
(b) City or town Jackson  
(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  
In this community years, months or days)

3. (a) PRINT FULL NAME

Alice Tipton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years Months Days If less than one day  
36 10 21 h. min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

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)

(Date received local registrar)

(b)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 7  
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Chr. Bronchitis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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 Wm J. Burton (M. D. or other)

Address 2000 Bureau Date signed

SUPPLEMENTAL

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

S-10578 1940