

1. PLACE OF DEATH:
 (a) County Jackson County
 (b) City or town Rural Prairie
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jackson County Emergency Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days (Specify whether
 In this community 4 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Oak Grove
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.

3. (a) PRINT FULL NAME Tipton, Samuel

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Francis 6. (c) Age of husband or wife if alive 92 years

7. Birth date of deceased September 26 1852
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 6 3 hr. min.

9. Birthplace Oak Grove Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Not employed

11. Industry or business

12. Name Albert Tipton

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

14. Maiden name Unknown

15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant J. A. Tipton

(b) Address 1508 E 37 st K.C. Mo

17. (a) Removal (b) Date thereof 4-1-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warrsburg Mo

18. (a) Signature of funeral director Mrs G B Webb, Son

(b) Address Oak Grove Mo

19. (a) Mar 31 1943 (b) F. M. Nichols
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30th
 year 1943 hour 1 minute 35 P.M.

21. I hereby certify that I attended the deceased from 3-25 1943 to 3-30 1943
 that I last saw him alive on 3-30-43 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Duration 2 wks

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: none Of operations

Of autopsy none

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 F. B. Dailey (M. D. or N.D.)
 Address Jackson Co Emory Hosp Date signed 3/31/43

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

MOTHER FATHER

S. No. 2
M-5-42
17-39
X32873

28
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C

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.....

Licensed Embalmer No. *235-3*

P. O. Address *Blee Springs Me*

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, fact should be so stated above.