

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

FILED MAR 13 1944 18

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 2046

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2/26/44 to
In this community 2/28/44
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1364a Hodiament
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Willis Tippit

3. (b) If veteran, name war None 3. (c) Social Security No. 410-14-9975

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Maggie Tippit 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased June 5th 1895
(Month) (Day) (Year)

8. AGE: Years 48 Months 8 Days 23 If less than one day hr. min.

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

10. Usual occupation Assembler

11. Industry or business Curtis Wright Corp.

MOTHER FATHER
12. Name Walton Tippit
13. Birthplace Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Bertha Vaughn
15. Birthplace Tennessee (City, town, or county) (State or foreign country)

16. (a) Informant Stella Grady
(b) Address 5600 Arsenal St.

17. (a) Burial (b) Date thereof Mar 1, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksville, Tenn

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Avenue

19. (a) MAD 1 1944 (b) J. F. Bruce
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 28
year 1944 hour _____ minute 11 P.M.

21. I hereby certify that I attended the deceased from 2/26/44
to 2/28/44, 1944
that I last saw him im alive on February 28th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Meningococcal meningitis Duration _____

Due to _____
Due to 6

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy purulent meningitis 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?

(Specify type of place) _____
While at work? _____ (e) Means of injury 1

23. Signature P. W. Maxwell (M. D. or other) _____
Address 5600 Arsenal St. Date signed 2-28-44

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.....

W. W. Wilkins
.....
Licensed Embalmer No. *3575*

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, fact should be so stated above.

No. 2B
-2-3-43
17-36930
X

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 582J-
Registrar's No. 2046

Registration District No. 218 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(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 Willis Tappert
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maggie 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 48 Months 8 Days..... If less than one day..... min.

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

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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....
19. (a) MAR 25 1940 (Date received local registrar) J. F. Bredeek (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1940 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... arrive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

