

24  
11  
U

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days  
(Specify whether  
In this community 9 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 213 W. Clayton  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fred J. Tipton

3. (b) If veteran, name war World War II

3. (c) Social Security No. Not available

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 27 1921  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>25</u>	<u>6</u>	<u>27</u>	hr. min.

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

10. Usual occupation Truck Driver

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

MOTHER FATHER

12. Name James E. Tipton

13. Birthplace Milan Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Bernice Sterling

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

16. (a) Informant Hospital Records, Veterans Administration  
(b) Address Excelsior Springs, Missouri

17. (a) Removal (b) Date thereof 1-24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Removed to: Milan, Missouri  
(Burial or cremation)

18. (a) Signature of funeral director Vivian Hope  
(b) Address Hope Funeral Home Excelsior Springs, Missouri

19. (a) 1/30/47 (b) Caroline Hutchings  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24  
year 1947 hour 6:42 minute A. M.

21. I hereby certify that I attended the deceased from January 15, 1947, to January 24, 1947  
that I last saw him alive on January 24, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis Pulmonary, Chronic advanced, active  
Duration Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: 3 B  
(Include pregnancy within 3 months of death)

Major findings: 1 3 B  
Of operations \_\_\_\_\_

Of autopsy No 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? EPA

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

23. Signature R. H. KAPLAN (M. D. or other) MD  
Address Veterans Administration Hospital Excelsior Springs, Missouri  
Signed 1/24/47

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

2-8-47

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

James A. Moles

Licensed Embalmer No.

3296

P. O. Address

Excelsior Spgs Mo

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.