

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Reg. 108,260

State File No. ....

FILED MAR 20 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 747

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

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>JEFF. BRKS. MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>COLUMBIA</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VET. ADM. HOSP.</u>		d. STREET ADDRESS (If rural, give location) <u>823 PANSELL</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>KELLEY</u> b. (Middle) <u>M.</u> c. (Last) <u>TIPTON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3/6/53</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/21/97</u>	
9. AGE (In years; less birthday) <u>55 yrs.</u>		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAXI SERVICE</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>ROCHEPORT, MISSOURI</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>JOHN TIPTON</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH PLOTT</u>	14. NAME OF HUSBAND OR WIFE <u>IDA TIPTON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD I</u>	16. SOCIAL SECURITY NO. <u>495-16-0200</u>	17. INFORMANT'S SIGNATURE OR NAME <u>V. A. HOSPITAL RECORDS</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>BRONCHIAL PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>TOXIC NEPHROSIS</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>V.A.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/2, 1953, to 3/6, 1953, that he was born 3/21/97, and that death occurred at 4:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>M.H. Harkins</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>V.A. HOSPITAL JEFF. BRKS. MO.</u>	23c. DATE SIGNED <u>3-6-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3-7-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>3-7-53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke, MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington</u>
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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Student Embalmer

Signed

*John S. Kennehan*

Licensed Embalmer No. *4199*

P. O. Address *St. Louis*

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.