

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17397

State File No. 2098

FILED MAY 21 1957

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2098</u>		
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>8 mo.</u>		c. CITY OR TOWN <u>Kansas City</u>		Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kansas City Tuberculosis Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>310 N. 12th St.</u>				
3. NAME OF DECEASED (Type or Print) <u>Samuel Tipton</u>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <u>5-3-1957</u>		(Month) (Day) (Year)		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>7-9-1885</u>		9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR: Months _____ Days _____		
10a. USUAL OCCUPATION <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Marcus L. Tipton</u>			13b. MOTHER'S MAIDEN NAME <u>Lily Mae Hubbard</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>M. S. Parks</u> ADDRESS <u>7125 Sni Bar Road</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>		ANTECEDENT CAUSES					002X	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____						
II. OTHER SIGNIFICANT CONDITIONS		DUE TO (c) _____						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>3-15</u> , 19 <u>57</u> , to <u>5-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-3</u> , 19 <u>57</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Edward P. Wetmore MD</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Tuberculosis Sanitarium</u> <u>Leeds, Mo.</u>		23c. DATE SIGNED <u>5-3-57</u>		
24a. BURIAL OR CREMATION (Specify) <u>Burial</u>		24b. DATE <u>May 6-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lathrop Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lathrop Mo</u>		
DATE REC'D BY LOCAL REG. <u>53-57</u>		REGISTRAR'S SIGNATURE <u>Neal Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>De Moss Creek</u> ADDRESS <u>Cameron, Mo</u>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Edward P. Altomare

1981 08 130

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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.....  
Signature of Student Embalmer

Signed *Harold L. Walker*.....

Licensed Embalmer No. *4588*.....

P. O. Address *Lexington, Va*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.