

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS FEB 10 1960**

**-60-004157**  
 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1046**

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>                             |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Mo.</b>   |   | Length of stay in 1b   | c. CITY OR TOWN <b>Sikeston</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Desloge Hospital</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>221 Watson, St.</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Howard</b> Middle <b>Glen</b> Last <b>Tiffany</b>   |   |  | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>-22</b> Year <b>-60</b>  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>9/19/1931</b>   | 9. AGE (last birthday)<br><b>28</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____<br>IF UNDER 24 HR<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Lincoln-Mercury</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Horton, Michigan</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |   | 13a. FATHER'S NAME<br><b>Orville Tiffany</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Louise Sparks</b>                          |  |
| 14. NAME OF HUSBAND OR WIFE<br><b>Frances Tiffany</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>  |  | 16. SOCIAL SECURITY NO.<br><b>371-30-9888</b>                              |  |
| 17. INFORMANT<br><b>Frances Tiffany, 221 Watson, St.</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>DUE TO (b) <b>Calcific mitral stenosis</b><br>DUE TO (c) <b>410X</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____  |   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION   |  | COUNTY   | STATE  |
| 21. I attended the deceased from <b>1-23-60</b> to <b>1-29-60</b> and last saw him alive on <b>1-27-60</b><br>Death occurred at <b>7:30 pm</b> <b>1-22-60</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Robert R. Peice M.D.</b>  |   |  | 22b. ADDRESS<br><b>1325 S. Grand</b>   |  | 22c. DATE SIGNED<br><b>1-28-60</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>2-1-60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jackson Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Jackson, Michigan.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 29 1960</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>                                   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Stanley H. Dixon*

Licensed Embalmer No.

4195

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.