

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

804

=61-024199

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED AUG 14 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Buchanan	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri	a. STATE Missouri	b. COUNTY Buchanan
Length of stay in lb 3 years		c. CITY OR TOWN St. Joseph, Missouri	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		d. STREET ADDRESS 3137 Summit Ave.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First JOSEPHINE Middle TIPTON Last	Month August Day 3 Year 1961

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) Mexico, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME W. C. Croswhite	13b. MOTHER'S MAIDEN NAME Lizzie Unknown	14. NAME OF HUSBAND OR WIFE Arthur X. Tipton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Daughter Address Mrs. Raymond Norman 3137 Summit Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with cardiac decompensation.	5 hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) _____	
DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of the right breast.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from **July 30, '61** to **August 3, 1961** and last saw her **alive** on **August 3, 1961**
Death occurred at **9:25 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John P. McDaniel MD</i>	22b. ADDRESS 902 Edmond Street	22c. DATE SIGNED 8/9/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE August 4, 1961	23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	23d. LOCATION (City, town, or county) Burlington, Kansas
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24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc. St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Aug 10, 1961	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF J.P.M. Daniel, M.D. MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eric J. Cherry*

Licensed Embalmer No. 4679

P. O. Address St Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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