

S. No. 2  
M-8-43  
5-17-39  
P1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 12 1946

Simpson  
25995  
State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 381

Primary Registration District No. 6178

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Reyer, Duncan  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 56 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105  
(c) City or town Reyer (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Capitola Tipton

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife J. A. Tipton 6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased Dec 7 1887 (Month) (Day) (Year)

8. AGE: Years 56 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Reyer Mo (City, town, or county) / (State or foreign country)

10. Usual occupation House wife

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

MOTHER FATHER { 12. Name Prentiss F Johnson  
13. Birthplace Reyer Mo (City, town, or county) / (State or foreign country)  
14. Maiden name Mary E McGowan  
15. Birthplace Reyer Mo (City, town, or county) / (State or foreign country)

16. (a) Informant J. Tipton (b) Address Reyer Mo

17. (a) Burial, cremation, or removal (b) Date thereof 7/20/46 (Month) (Day) (Year)

(c) Place: burial or cremation Humphrey Cem  
18. (a) Signature of funeral director Schuman  
(b) Address \_\_\_\_\_

19. (a) Date received local health (b) Mrs. H. B. Harris (Registrar's signature)  
Date signed 7-19-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 18 year 1946 hour 2 minute 30 p.m.

21. I hereby certify that I attended the deceased from 1942 to July 18 1946 that I last saw her alive on July 2 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic hepatitis, interstitial cystitis, chronic myocardiopathy. Duration 5 yrs. Unknown  
Due to: Hypertension

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

Major findings: Of operations 1318 Of autopsy \_\_\_\_\_

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?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature: E. Simpson (M. D. or other) Address: Milan Date signed 7-19-46

Duration  
Underline the cause to which death should be charged statistically.

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

320

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 10  
District File Number 8-46-1487  
Date Filed AUG 10 1946

**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 Dwight Scherer  
Licensed Embalmer No. 2667  
P. O. Address Milan

**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.**