

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7796

State File No. ....

FILED FEB 27 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4515 Registrar's No. 21

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>SULLIVAN</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MILAN</u> |  | c. CITY OR TOWN <u>Milan</u>   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (In this place) <u>24 days</u>  |  | e. STREET ADDRESS (If rural, give location) <u>No State Street 1050</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sullivan Co. Memorial</u>                      |  |  |   |

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|--|--|---|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>ELIZABETH</u> b. (Middle) <u>JOSE</u> c. (Last) <u>MAE TIPTON</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>2 14 1956</u> |  |  |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>             |  | 7. <del>MARRIED</del> NEVER MARRIED, WIDOWED, DIVORCED (Specify)   |  |
| 8. DATE OF BIRTH <u>11-25-1893</u>   |  | 9. AGE (In years last birthday) <u>62</u> |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>           |  | 10b. KIND OF BUSINESS OR INDUSTRY         |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>MILAN MO</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |   |  |  |  |

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|--|--|--|--|--|--|
| 13a. FATHER'S NAME <u>WILLIAM ANDREW DENNIS</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>MARGARET ANN CALDWELL</u> |  | 14. NAME OF HUSBAND OR WIFE <u>JOHN KESSINGER TIPTON</u>             |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. _____                          |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JOHN K TIPTON MILAN</u> |  |

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic pneumonia</u>   |  | DUE TO (b) <u>Malnutrition</u>   |  |  |  | <u>5 days</u>   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  |  | DUE TO (c) <u>Deprivation of food intake</u>                                   |  |  |  | <u>5 days</u>   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  | <u>Cerebral hemorrhage, cerebrospinal meningitis, not due to meningococcus</u> |  |  |  | <u>2 weeks</u>  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION <u>331x</u>                                   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 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) (Min.) |  | 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 1-21, 1956, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 10:30P., from the causes and on the date stated above.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 23a. SIGNATURE (Degree or title) <u>Joseph E. Prior, D.O.</u> |  | 23b. ADDRESS <u>217 E. Second St., Milan, Mo.</u>                         |  | 23c. DATE SIGNED <u>2-15-56</u>                   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>       |  | 24b. DATE <u>2-17-56</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD</u> |  |
| 24d. LOCATION (City, town, or county) (State) <u>MILAN MO</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Beggs Funeral Home, Milan</u> |  |   |  |
| DATE REC'D BY LOCAL REG. <u>2-18-56</u>                       |  | REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>                           |  | 525-0   |  |

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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.....  
*Russell E. Leggin*

Licensed Embalmer No. 379

P. O. Address *Melan, 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.