

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006105

STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 75

300
1-57

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OKLAHOMA b. COUNTY OTTAWA	
b. CITY OR TOWN JOPLIN		c. CITY OR TOWN FAIRLAND	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First FERDINAND Middle ANDREW Last TIPTON			4. DATE OF DEATH Month JANUARY Day 8 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1881		9. AGE (In years last birthday) 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and state or country) MISSOURI		
10c. CITIZEN OF WHAT COUNTRY? U.S.A.						

13a. FATHER'S NAME GEO. WASHINGTON TIPTON	13b. MOTHER'S MAIDEN NAME ELVA CLEMONS	14. NAME OF HUSBAND OR WIFE ----
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) UNK	16. SOCIAL SECURITY NO.	17. INFORMANT L. W. TIPTON, FAIRLAND, OKLAHOMA
--	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia		INTERVAL BETWEEN ONSET AND DEATH undetermined
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)		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.)	
20c. TIME OF INJURY		

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 _____, to _____ and last saw her alive on _____
Death occurred at **7:55 PM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Roland T Smith, M.D. (Degree or title)	22b. ADDRESS Medical Arts Bldg, Joplin, Mo.	22c. DATE SIGNED 1-15-59
--	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-11-59	23c. NAME OF CEMETERY OR CREMATORY HICKORY GROVE, NEAR FAIRLAND, OKLAHOMA	23d. LOCATION (City, town, or county) (State)
---	--------------------------	--	---

24. FUNERAL DIRECTOR COOPER FUNERAL HOME, MIAMI, OKLA.	25. DATE RECD. BY LOCAL REG. 2-10-1959	26. REGISTRAR'S SIGNATURE Dove Merriam
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address *Joplin, 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.