

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED OCT 25 1989

REGISTRATION DISTRICT NO.

REGISTRAR'S NUMBER

DELAYED 235044

124 - 24-037013

DO NOT WRITE
 ON THIS STUB

TYPE/PRINT
 IN
 PERMANENT
 BLACK INK.
 FOR

INSTRUCTIONS
 SEE OTHER SIDE
 AND HANDBOOK.

DECEDENT

VS 300
 Rev. 1/89
 MO 580-0695
 (1-89)

FOR USE BY PHYSICIAN OR INSTITUTION

NAME OF
 DECEDENT

1. DECEDENT'S NAME (First, Middle, Last) Pearl Sartain Tindall				2. SEX Female		3. DATE OF DEATH (Month, Day, Year) January 4, 1924	
4. SOCIAL SECURITY NO. N/A		5a. AGE - Last Birthday (Years) 29	5b. UNDER 1 YEAR MONTHS DAYS	5c. UNDER 1 DAY HOURS MINUTES		6. DATE OF BIRTH (Month, Day, Year) October 18, 1894	
7. BIRTHPLACE (City and State or Foreign Country) Howard County, Missouri		8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.					
9a. PLACE OF DEATH (check only one; see instructions on other side) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (specify)							
9b. FACILITY NAME (If not institution, give street and number) Street & Number Unknown				9c. CITY, TOWN, OR LOCATION OF DEATH Pineville		9d. COUNTY OF DEATH McDonald	
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) John Jerry Tindall		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE - STATE Missouri		13b. COUNTY McDonald		13c. CITY, TOWN, OR LOCATION Pineville		13d. ZIP CODE N/A	
13e. STREET AND NUMBER Unknown				13i. INSIDE CITY LIMITS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13g. YEARS AT PRESENT ADDRESS <input checked="" type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20 or more	
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:				15. RACE - American Indian, Black, White, etc. (Specify) White		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9	

PARENTS

17. FATHER'S NAME (First, Middle, Last) James Lemuel Sartain		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lizzie Ellen Ford	
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INFORMANT

19a. INFORMANT'S NAME (Type/Print) Helen Margaret Tindall Polly		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 870 Sun Valley Drive, Columbia, MO 65201	
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DISPOSITION

20a. BURIAL, CREMATION, OTHER (Specify) Burial		20b. DATE OF DISPOSITION (Month, Day, Year) January 6, 1924	20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Walnut Ridge Cemetery	20d. LOCATION - City or Town, State Fayette, Missouri	
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SEE INSTRUCTIONS ON OTHER SIDE

CAUSE OF DEATH

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Not available, Dec'd.		22a. NAME AND ADDRESS OF FACILITY Guy T. Halley, Fayette, Missouri		22b. FUNERAL ESTABLISHMENT LICENSE NUMBER Unknown	
23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death 9 days
IMMEDIATE CAUSE (Final disease or condition resulting in death) Pneumonia		a. DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):			
c. DUE TO (OR AS A CONSEQUENCE OF):		d. DUE TO (OR AS A CONSEQUENCE OF):			

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.		25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY M	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				

CERTIFIER

28a. (Specify) <input type="checkbox"/> CERTIFYING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL EXAMINER/CORONER		28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) Helen M. Polly, daughter		28c. DATE SIGNED (Month, Day, Year) 10/18/89		28d. TIME OF DEATH approx 2:00 A.M.	
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)				29b. MO. LICENSE NUMBER		30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No	
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			32. REGISTRAR'S SIGNATURE			33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year)	

Filed on the basis of a notarized statement from Helen M. Polly (daughter) Newspaper account of death in Fayette Advertiser 1/20/24. (State) from attending physician signed and notarized 3/17/30.

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 _____

Licensed Embalmer No. _____

P.O. Address _____

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

SEE EXAMPLES BELOW.

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. <u>Rupture of myocardium</u> DUE TO (OR AS A CONSEQUENCE OF):					Mins.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF):					6 days
	c. <u>Chronic ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF):					5 years
	d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
<u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>						
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.						25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED	
	27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	_____	_____				

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. <u>Cerebral laceration</u> DUE TO (OR AS A CONSEQUENCE OF):					10 mins.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. <u>Open skull fracture</u> DUE TO (OR AS A CONSEQUENCE OF):					10 mins.
	c. <u>Automobile accident</u> DUE TO (OR AS A CONSEQUENCE OF):					10 mins.
	d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.						25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED	
	27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)	27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	_____	_____				
	_____	_____				