N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25321

1. PLACE OF DEATH
County New Madrid — Registration District No. 605 — File No.
Township — Primary Registration District No. 4359 — Registered No.
City Parma (No. ..... St. ..... Ward)

2. FULL NAME Phil Tinker
(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Rosettie Tinker

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1867-12-30

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
61	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: R R Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn

PARENTS
10. NAME OF FATHER: Phillip Tinker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): U.S.A.
12. MAIDEN NAME OF MOTHER: Anna Graham
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): USA

14. INFORMANT: Rosettie Tinker
(Address): Parma Mo

15. FILED 7/15 1929 Mrs C S Blackman By Mrs V. B. S. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 14th 1929

17. I HEREBY CERTIFY, That I attended deceased from July 13th, 1929, to July 14th, 1929 that I last saw h.w.w.w. alive on July 14th 1929 and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Insufficiency
940
950
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY): Angina Pectoris
(duration) yrs. mos. — ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. S. Davis, M. D.
, 19 (Address) Parma

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mauldin
DATE OF BURIAL: 7/16 1929

20. UNDERTAKER: J. C. Night
ADDRESS: Parma