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

FILED JUL 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

21764

State File No.

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 541

1. PLACE OF DEATH:

(a) County GREENE.

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St Johns Hosp. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town Springfield (If outside city or town limits, write "RURAL")

(d) Street No. 1945 N. Grant Ave, (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

(a) FIRST NAME Chesa MAE. (b) LAST NAME TYNDALL 534

3. (b) If veteran, name war ✓ none 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Robert Tyndall 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Jan (Month) 3 (Day) 1892 (Year)

8. AGE: Years ✓ 48 Months 5 Days 22 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Mo. (State or foreign country) 6

10. Usual occupation House Wife 1

11. Industry or business In home

FATHER 12. Name William King 9

13. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country)

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) — (State or foreign country)

16. (a) Informant Robert Tyndall

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. N. Klingner Co.

(b) Address Springfield Mo.

19. (a) June 27, 1940 (Date received local registrar) (b) W. E. Hardley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1940 hour 1 minute 05 P. M.

21. I hereby certify that I attended the deceased from June 22, 1940, to June 25 — 1940, that I last saw her alive on June 25 — 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia and edema lungs	2 days
Due to: ~~Toxemia~~ Pheno-barbital Poisoning	3 days
Due to: over dose of accumulative	
Other conditions (Include pregnancy within 3 months of death): Epileptic attacks for 12 years	

Major findings:
Of operations None
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence June 22-1940

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? ✓ (e) Means of injury ✓

(f) Signature E. M. Herreden (M. D. or other)

Address Springfield Mo Date signed 6/27/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

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 this body is not embalmed, above space should be left blank.