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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 27 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 60

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME MYRTLE TINSLEY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color of race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife D.C.

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased December 25, 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 11 If less than one day
hr. min.

9. Birthplace Liberty, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife
Home

11. Industry or business

MOTHER FATHER

12. Name Frank, Grooms

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

14. Maiden name Unknown

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

16. (a) Informant D.C. Tinsley (Husband)

(b) Address 623 Mason Ave., City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director John A. Jenkins

(b) Address 6054 Pryor Ave., City

19. (a) 1-18-47 (Date received local registration)

(b) W. L. Jenkins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 623 Mason Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6
year 1947 hour 2 minute 20 A.M.

21. I hereby certify that I attended the deceased from
January 4, 1947, to January 5, 1947,
that I last saw her alive on January 5, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory failure

Due to Arteriosclerotic Heart Disease

Due to

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations 93D

Of autopsy

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

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

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

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

(Specify type of place) (e) Means of injury

23. Signature Wm. S. Stearns (M. D. or other) MD
407 First Bldg. Address Date signed Jan 47

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 *John E. Rupp* _____

Licensed Embalmer No. *3986* _____

P. O. Address *St. Joseph, 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 this body is not embalmed, fact should be so stated above.