FILED JUL 18 1949

No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23268

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5551 Registrar's No. 76

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL Howell Twp.
c. LENGTH OF STAY (in this place): 15 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Plains, Mo. Rt. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Howell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Plains Rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Samuel b. (Middle) Joseph c. (Last) Tiner

4. DATE OF DEATH (Month) July (Day) 3, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept. 27, 1873

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months 9, Days 6 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Pocahontas, Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: James Burke Tiner

13b. MOTHER'S MAIDEN NAME: Cynthia Ellen Alphin

14. NAME OF HUSBAND OR WIFE: Kansas Victoria Summers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS: Mrs. M. M. Adams, West Plains, Mo. Rt. 1

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Haemorrhage from lungs — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Crushed chest —
DUE TO (c) E92841

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Broken Rt. Hip. 3

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: no operation

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): farm

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Howell Township, Howell, Mo.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Jul. 3, 1949 m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Attacked by mad bull 46

22. *I hereby certify that I attended the deceased* ~~from~~ Shortly after death —, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. H. Thoroughman, M.D.

23b. ADDRESS: West Plains, Mo.

23c. DATE SIGNED: 7/5/49.

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Jul. 6, 1949

24c. NAME OF CEMETERY OR CREMATORY: Howell Valley Cem.

24d. LOCATION (City, town, or county) (State): Howell Twp. Howell Co. Mo.

DATE REC'D BY LOCAL REG.: 7-7-49

REGISTRAR'S SIGNATURE: Beatrice Cook

25. FUNERAL DIRECTOR'S SIGNATURE: Hal Thoroughman — ADDRESS: W. Plains, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 7-11-49.
[illegible] Officer No. 5,
District [illegible] 749426
Date Filed 7-14-49

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 _____
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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.