FILED SEP 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32693

BIRTH NO. 54461-49 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 105

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

1. PLACE OF DEATH
a. COUNTY Scott
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sikeston
c. LENGTH OF STAY (in this place) 30 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mo. Delta Comm. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri
b. COUNTY Scott
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sikeston
d. STREET ADDRESS (If rural, give location) 226 Dorothy

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) Robert
c. (Last) Lindley

4. DATE OF DEATH (Month) Aug. (Day) 18 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Aug-18-1949
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Sikeston, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Charles G. Lindley
13b. MOTHER'S MAIDEN NAME Doris Ann ~~Kimp~~ Kempe
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Charles G. Lindley, Father, **ADDRESS** Sikeston Mo

18. CAUSE OF DEATH 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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity (6 months) — INTERVAL BETWEEN ONSET AND DEATH 45 min

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

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-18, 1949, *to* 8-18, 1949, *that I last saw the deceased alive on* 8-18, 1949, *and that death occurred at* 7:24 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) A. S. Martin M.D.
23b. ADDRESS Sikeston, Mo.
23c. DATE SIGNED 8-20-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-19-49
24c. NAME OF CEMETERY OR CREMATORY Memorial Park
24d. LOCATION (City, town, or county) Sikeston (State) Mo

DATE REC'D BY LOCAL REG. Sept 6-49
REGISTRAR'S SIGNATURE Mrs Ella Hunter 429
25. FUNERAL DIRECTOR'S SIGNATURE Welsh Funeral Home **ADDRESS** Sikeston Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED SEP 12 1949
District Health Office No. 2,
District File Number 044-899
Date Filed

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

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.