

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4549**

BIRTH FILED **MAR 8 1954** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **236**

1. PLACE OF DEATH a. COUNTY Bremer		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Shelton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Walnut Grove	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) R R # 2	

3. NAME OF DECEASED (Type or Print) a. (First) MACK	b. (Middle)	c. (Last) LINDSEY	4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 26 - 1954
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5. SEX MAL	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH OCT. 31 - 1877	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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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 (City and State or Foreign Country) State of Tennessee	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME George Lindsey	13b. MOTHER'S MAIDEN NAME Emily Lindsey	14. NAME OF HUSBAND OR WIFE never married
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15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Ivan Lindsey	ADDRESS R 2 Walnut Grove - Mo
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18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cholera - Rapid Vomiting Disease	ANTECEDENT CAUSES		NOT KNOWN
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS		
	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2-3**, 19**54**, to **2-26**, 19**54**, that I last saw the deceased alive on **12-30**, 19**54**, and that death occurred at **6:40 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE May Vebb	(Deputy or Notary)	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 2-26-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 28 - 54	24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State) Willard, Mo.
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DATE REC'D BY LOCAL REG. 3-1-54	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Brim - Daniel Oak Grove - Mo	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *Wayne L. Samuel*

Licensed Embalmer No. *470*

P. O. Address *Asht Grove*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.