

health, Welfare public service  
 300 1-56  
 All diseases in Part I must be cosually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

41774

FILED DEC 21 1956

STATE FILE NUMBER 5287

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5287

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>COLEMAN NURSING HOME 57 YEARS</b>		Length of stay in 152	
d. STREET ADDRESS <b>2805 DENVER AVE</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>TINDALL</b>			4. DATE OF DEATH Month <b>DEC</b> Day <b>3</b> Year <b>1956</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC-6-1872</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER (RETIRED)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>A.T. SWITZER PAINT CO.</b>	11. BIRTHPLACE (City and state or country) <b>GRIMSBY ENGLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>BENJAMIN TINDALL</b>	14. MOTHER'S MAIDEN NAME <b>JANE SHAKESPEARE</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>486-07-0852</b>	17. INFORMANT <b>Mrs. MARGARET MILLER</b> Address <b>2805 DENVER AVENUE KANSAS CITY, MO.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction Acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>4201H</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinome prostate - metastasize</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour _____ a. m. _____ p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <b>Feb 47 to Dec 3, 56</b> and last saw him <b>alive on Dec 1, 56</b> Death occurred at <b>7:40 p. m.</b> on the date stated above and to the best of my knowledge, from the causes stated.
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22. SIGNATURE (Doctor or the) <b>J. D. Bennett MD</b>	22b. ADDRESS <b>K.C. Mo 409 E 63rd</b>	22c. DATE SIGNED <b>12/4/56</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>DEC-6-1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER SONS</b> ADDRESS <b>1331 K.P. MO BRUSH CREEK BLVD</b>	25. DATE RECD. BY LOCAL REG. <b>12-5-56</b>	26. REGISTRAR'S SIGNATURE <b>Heav Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 J. D. Bennett

MEDICAL CERTIFICATION

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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 *Everett L. Smith*

Licensed Embalmer No. *50*

P. O. Address *K. C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.