

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024401

STATE FILE NUMBER

FILED JUN 24 1958 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 92

5-300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Fairview 750°</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 3 4448 1958</u> Length of stay in lb <u>4448 1958</u>		d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>THOMAS TICHENOR</u>			4. DATE OF DEATH Month Day Year <u>5 28 1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1878</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>79</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state & country) <u>Newton Co., Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13a. FATHER'S NAME <u>Taranza Tichenor</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Wright</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Hospital records</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>442X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mental deficiency</u>			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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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
21. I attended the deceased from <u>3/1/1956</u> to <u>5/28/1958</u> and last saw her alive on <u>5/28/1958</u> Death occurred at <u>3:10 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. C. Bendley M.D.</u> (Degree or title)		22b. ADDRESS <u>State Hospital #3, Nevada, Mo.</u>	22c. DATE SIGNED <u>5/28/1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>5-28-58</u>	<u>Rocky Comfort</u>	<u>Rocky Comfort, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hays Funeral Service, Inc. Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-17-1958</u>	26. REGISTRAR'S SIGNATURE <u>Arnal & Jerry</u>

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Richard Lee Griffith, Student Embalmer No. 530 working under my personal supervision.

Student Richard Griffin
Signature of Student Embalmer

Signed Allen V. Hoops

Licensed Embalmer No. 1968

P. O. Address Nevada, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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