

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004121  
STATE FILE NUMBER

FILED FEB 6 1959 Registration District No. 328 Primary Registration District No. 3073 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CHAFFEE</b>		c. CITY OR TOWN <b>CHAFFEE</b> 10010 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>209 BLACK AVE</b>		d. STREET ADDRESS (If outside, give location) <b>209 BLACK AVE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b <b>12 YRS.</b>			

3. NAME OF DECEASED (Type or print) First <b>MORRIS</b> Middle <b>P.</b> Last <b>TINDER</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1896</b>		9. AGE (In years last birthday) <b>62</b>	FUNDER 1 YEAR Months <b>2</b> Days <b>27</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROGGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>		11. BIRTHPLACE (City and state or country) <b>STURGEON, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>JOHN T. TINDER</b>		13b. MOTHER'S MAIDEN NAME <b>EMMA TORLSON</b>		14. NAME OF HUSBAND OR WIFE <b>VIRGIE M. TINDER</b>	
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>493-09-6141</b>		17. INFORMANT Address <b>MRS. VIRGIE M. TINDER - CHAFFEE, Mo.</b>	

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>Peripheral Vascular Collapse</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral thrombosis</b>			<b>24 hrs.</b>
	DUE TO (c) <b>Cardio-Vascular-Renal arteriosclerosis</b>			<b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>442 X</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.)		
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a.m. <b></b> p.m. <b></b>					
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 <b>1-22-59</b> , to <b>1-29-59</b> , and last saw <sup>her</sup> <sub>him</sub> alive on <b>1-28-59</b> Death occurred at <b>2:35 PM.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Dr. H. Schmeyer, D.O.</b>			22b. ADDRESS <b>Chaffee, Missouri</b>		22c. DATE SIGNED <b>1/30/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB. 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SIKESTON MEMORIAL GARDENS</b>	23d. LOCATION (City, town, or county) (State) <b>SIKESTON, MISSOURI</b>
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24. FUNERAL DIRECTOR ADDRESS <b>BISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Jan 31, 59</b>	26. REGISTRAR'S SIGNATURE <b>Mustel Buehling</b>
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(Licensed Embalmers Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

6961 6 834'

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 *Jack T. Burnett* .....  
Licensed Embalmer No. *4473* .....  
P. O. Address *Chaffee, Md* .....

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.