

FILED FEB 16 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004634  
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 145

300  
-57 0

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u> <u>0117</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth. Hospital</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>403 Virginia St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WESLEY</u> Last <u>TINDLE</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1876</u>		9. AGE (In years last birthday) <u>83</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>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stock Yds. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>James Tindle</u>		
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Cecelia Tindle</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>Unknown</u>		17. INFORMANT <u>Cecelia Tindle, 403 Virginia, City</u> Address _____	
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>Left Lober Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u>					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</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 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 _____	
21. I attended the deceased from <u>1/27/59</u> to <u>1/29/59</u> and last saw her alive on <u>1/28/59</u> Death occurred at <u>4:00 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Wm W. Blair, MD</u> (Degree or title)		22b. ADDRESS <u>Social Welfare Board, 10th &amp; Olive, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>1/30/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1/31/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Robinson, Kansas</u>	
23d. LOCATION (City, town, or county) <u>Robinson, Kansas</u>		23e. STATE <u>Kansas</u>			
24. FUNERAL DIRECTOR <u>John E. Rupp</u> ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 10, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Wm Clark Goodell</u>	

All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.  
 MEDICAL CERTIFICATION  
 Dr. Owen W. D. Craig

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 *John E. Keupp* .....

Licensed Embalmer No. *3986* .....

P. O. Address *St. Joseph* .....

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.