

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030851

FILED VS SEP 1 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7524** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b> 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>Enroute City Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3936a Lafayette Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>U.</b> Last <b>Tinnon</b>			4. DATE OF DEATH Month <b>August</b> Day <b>12</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>8/8/1929</b>	9. AGE (last birthday) <b>30</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operations Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KTVI Television</b>	11. BIRTHPLACE (City and state or country) <b>Tyler, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Carl Tinnon</b>		13b. MOTHER'S MAIDEN NAME <b>Velma Elliott</b>		14. NAME OF HUSBAND OR WIFE <b>Patricia Rose</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W.W. 2</b>	16. SOCIAL SECURITY NO. <b>494-24-5973</b>	17. INFORMANT <b>Patricia R. Tinnon</b>	Address <b>3936a Lafayette Ave.</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>Fracture of base of Skull</b> DUE TO (b) <b>Fractured of Ribs with Hemorrhage in both pleural cavities</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the immediate disease condition given in PART I (a)) <b>Supplied with car strapped with seat belt, struck light standard, at Express Highway and Chateau about 9:05 a.m. Aug 12 1959.</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in PART I or PART II of item 18.) <b>struck light standard, at Express Highway and Chateau</b>
20c. TIME OF INJURY Hour <b>9:05</b> a.m. Month, Day, Year <b>8 12 1959</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>
20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY STATE

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Joseph M. Smith</i> (Degree or title) <b>Joseph M. Smith, Registrar</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>8/13/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/17/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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FUNERAL DIRECTOR <b>Morrell Mortuary, 3710 North Grand</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 13 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Laron E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis

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