URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

[redacted]

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1696 STATE FILE NUMBER -60-008999

ENDED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. — Length of stay in 1b 26 yrs. 3mo 11 days	c. CITY OR TOWN St.Louis, Mo. — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital — Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) 4417 West Belle Pl. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First WALTER	Middle	Last TYNDALL	4. DATE OF DEATH	Month Feb. Day 10, Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 4-22-1896	9. AGE (last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days; IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) formerly: laborer	10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Thomas Tyndall	13b. MOTHER'S MAIDEN NAME Mary ?		14. NAME OF HUSBAND OR WIFE Nellie Otey Tyndall		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War I	16. SOCIAL SECURITY NO. None		17. INFORMANT Nellie Tyndall	Address 4417 West Belle	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of splenic flexure of colon

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 153.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Malnutrition due to above

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Oct. 30, 1933, to Feb. 10,1960 and last saw her/him alive on Feb. 10, 1960

Death occurred at 10:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

L. Hofstetter, M.D.

22a. SIGNATURE (Degree or title) L. Hofstetter M.D.	22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 2-11-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/15/60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, 4107 Finney	25. DATE RECD. BY LOCAL REG. FEB 14 1960	26. REGISTRAR'S SIGNATURE Earl Smith. M.D. MDC.	

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Gryton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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