

FILED MAY 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15599**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **458**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield	c. LENGTH OF STAY (in this place) 3 mo.	c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bunge Hospital		d. STREET ADDRESS (If rural, give location) 1416 Concord	

3. NAME OF DECEASED (Type or Print) a. (First) ALLEN b. (Middle) C. c. (Last) TINDALL	4. DATE OF DEATH (Month) (Day) (Year) 5-21-49
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH Feb. 1, 1904	9. AGE (In years last birthday) 45 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work including most of working life, even if retired) Insurance Salesman	10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (State or foreign country) Springfield Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Chas. A. Tindall	13b. MOTHER'S MAIDEN NAME Susan French	14. NAME OF HUSBAND OR WIFE Louise Tindall
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 491-03-2400	17. INFORMANT'S SIGNATURE OR NAME Louise Tindall	ADDRESS Spfld.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Approx. 3 hrs 443'X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardio-vascular disease DUE TO (c) disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Springfield Greene Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **7 Feb**, 1949, to **May 21**, 1949, that I last saw the deceased alive on **21 May**, 1949, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Henry F. Knott Jr.	(Degree or title)	23b. ADDRESS 1116 So. N. Jefferson Spfld. Mo.	23c. DATE SIGNED 23 May 49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 5-25-49	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town or county) (State) Springfield Mo.
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DATE REC'D BY LOCAL REG. 5/24/49	REGISTRAR'S SIGNATURE W.B. Handley	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co	ADDRESS Spfld. Mo.
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JUN 1 1949

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.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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