

FILED DEC 27 1949 STANDARD CERTIFICATE OF DEATH

40854

State File No.

BIRTH NO. 79785-49 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1114

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Wright	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Mansfield	
c. LENGTH OF STAY (In this place) 5 minutes		d. STREET ADDRESS (If rural, give location) No Street	
d. FULL NAME OF (If in hospital or institution, give street address or location) St. John's Hospital			

3. NAME OF DECEASED a. (First) Baby		b. (Middle)		c. (Last) Tinker		4. DATE OF DEATH (Month) (Day) (Year) 12 16 49	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant		8. DATE OF BIRTH 12-16-49	
9. AGE (In years last birthday) 0 0 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (State or foreign country) Springfield, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William Wesley Tinker		13b. MOTHER'S MAIDEN NAME Laura Emogene Smith		14. NAME OF HUSBAND OR WIFE -----			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 0		17. INFORMANT'S SIGNATURE OR NAME Mr. Tinker, Mansfield, Mo.		ADDRESS	
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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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anencephalic monster with		ANTECEDENT CAUSES				Congenital	
DUE TO (b) Spina bifida + Dystocardia		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
DUE TO (c) Congenital Deformities		II. OTHER SIGNIFICANT CONDITIONS				750X	
Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12-16, 1949, to 12-16, 1949, that I last saw the deceased alive on 12-16, 1949, and that death occurred at 10²² a.m., from the causes and on the date stated above.

23a. SIGNATURE J. L. Johnston (Degree or title)		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 12-17-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec 16, 1949		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri	
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DATE REC'D BY LOCAL REG. 12-21-49		REGISTRAR'S SIGNATURE W. E. Haddley		25. FUNERAL DIRECTOR'S SIGNATURE Alma Schmeyer		ADDRESS Springfield, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORDS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by ~~me~~ or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Bernard F. Wright

Licensed Embalmer No. 4293

P. O. Address Springfield, V.

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.