

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14852**
Registrar's No. **3849**

FILED MAY 1 - 1952

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY New Madrid			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 44 Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Parma		0720	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnard Free Skin & Cancer Hosp.				d. STREET ADDRESS (If rural, give location) R.R. #2			
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) A.		c. (Last) Tinker		4. DATE OF DEATH (Month) (Day) (Year) 4 23 52	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 5 9 1892		9. AGE (In years last birthday) 59	10. IF UNDER 1 YEAR Months Days 11 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Parma, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Phillip Tinker			13b. MOTHER'S MAIDEN NAME Rosa Pope		14. NAME OF HUSBAND OR WIFE Anna Tinker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) U.S.A.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Hospital Record - Barnard Hospital			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Stomach</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 137X			
22. I hereby certify that I attended the deceased from <u>3-11</u> , 1952, to <u>4-23</u> , 1952, that I last saw the deceased alive on <u>4-23</u> , 1952, and that death occurred at <u>3:32 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Herin Kellain</u>				23b. ADDRESS M.D. Barnard Hospital - St. Louis Mo.		23c. DATE SIGNED 4-23-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-23-52	24c. NAME OF CEMETERY OR CREMATORY Malden		24d. LOCATION (City, town, or county) (State) Malden, Mo.		
DATE REC'D BY LOCAL REG. APR 23 1952		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.			

April 8 1952
7337

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed..... *John S. Dennehy*

Licensed Embalmer No. *4194*

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.