

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002607

STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 314 Primary Registration District No. 6064 Registrar's No. 5

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Clair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Osceola rural</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Osceola 0930</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Waite Rest home</b>		Length of stay in 1b <b>16 MO.</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>C.</b> Last <b>Tinsley</b>			4. DATE OF DEATH Month <b>I</b> Day <b>23</b> Year <b>1959</b>
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-1860</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years birthday) <b>98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Illinois</b>
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Gibson</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Clyde Tinsley Eldorado Springs Mo</b>
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>interosclerotic heart disease c decompensation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4200</b>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>1 July 58</b> to <b>23 Jan 59</b> and last saw her alive on <b>23 Jan 59</b> Death occurred at <b>9:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>resler M D C</b>		22b. ADDRESS <b>Osceola Mo</b>	22c. DATE SIGNED <b>26 Jan 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>I-25-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Osceola Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Osceola Mo.</b>
24. FUNERAL DIRECTOR <b>Goodwill F. Home Osceola Mo</b>		25. DATE RECD. BY LOCAL REG. <b>1-28-1959</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Seever</b>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Student .....  
Signature of Student Embalmer

Signed *Paul Thurstone*

Licensed Embalmer No. *3990*  
P. O. Address *Osceola, Mo.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.