

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022594
STATE FILE NUMBER

FILED JUN 23 1959 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 237

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-57

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BONNE TERRE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ELVINS, Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BONNE TERRE</u>		Length of stay in lb <u>5 hrs.</u>	094 ^d STREET ADDRESS (If outside, give location) <u>o</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT L. JINSLEY</u>			4. DATE OF DEATH Month Day Year <u>June 10 1959</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 22, 1927</u>	9. AGE (In years last birthday) <u>31</u>	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILKING</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ELVINS, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOE TINSLEY</u>	13b. MOTHER'S MAIDEN NAME <u>LUCINDA WELLS</u>	14. NAME OF HUSBAND OR WIFE <u>NORMA JEAN TINSLEY</u>
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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) <u>YES</u> <u>JAN. 1946-1948</u>	16. SOCIAL SECURITY NO. <u>498-24-2534</u>	17. INFORMANT <u>Joe Tinsley Elvins, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mediastinal Emphysema</u> <u>Chest Injury</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>hours</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 minutes</u>
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 checked="" 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.) <u>Automobile Accident</u>
20c. TIME OF INJURY <u>2:50</u> a.m. p.m. <u>6-10-1959</u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 32, Flat River, Mo</u>	20f. CITY, TOWN, OR LOCATION <u>Flat River</u>	COUNTY <u>St. Francois, Missouri</u>	STATE
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21. I attended the deceased from <u>6-10-59</u> to <u>6-10-59</u> and last saw ^{her} alive on <u>6-10-59</u> Death occurred at <u>6:15 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>W. Paul Dennis M.D.</u>	22b. ADDRESS <u>Flat River, Missouri</u>	22c. DATE SIGNED <u>6/12/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>June 13, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leadwood</u>	23d. LOCATION (City, town, or county) (State) <u>Leadwood, Mo.</u>
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24. FUNERAL DIRECTOR <u>Raymond Colwell and Sons Flat River, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 18, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Catherine Rudloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

EX-78 (MAY)

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 *R. Caldwell*

Licensed Embalmer No. *2531*
P. O. Address *Flat River*

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.