

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-041719**

FILED VS. NOV 28 1960

Registration District No. 128 Primary Registration District No. \_\_\_\_\_ Registrar's No. 1175

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lawrence</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Republic</u>		Length of stay in lb <u>few minutes</u>		c. CITY OR TOWN <u>MT VERNON</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>HiWay 166</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>MT VERNON CLINIC</u> <u>HiWay 166</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Sandy</u> Middle <u>Louise</u> Last <u>TINKLEPAUGH</u>				4. DATE OF DEATH Month <u>Nov</u> - Day <u>21</u> - Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-21-60</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>6</u> Min.	IF UNDER 24 HR Hours <u>6</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MT VERNON, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Harry Tinklepaugh</u>			13b. MOTHER'S MAIDEN NAME <u>Lorane Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [(If yes, give war or dates of service)]			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry Tinklepaugh Monett, Mo.</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>							<u>2 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Mucus Plug</u>							<u>4 1/2 hrs.</u>		
DUE TO (c) <u>Unknown Cause</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Pre mature Infant</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Nov 21 1960</u> to <u>Nov 21 1960</u> and last saw her <u>alive</u> on <u>Nov 21 1960</u> Death occurred at <u>1:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>David G. George D.O.</u>				22b. ADDRESS <u>MT VERNON MO</u>			22c. DATE SIGNED <u>Nov 22 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		23d. LOCATION (City, town, or county) <u>Marionville Mo</u>					
24. FUNERAL DIRECTOR <u>Max L. Lunett</u>			ADDRESS <u>MT VERNON MO</u>		25. DATE RECD. BY LOCAL REG. <u>11-23-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max L. Fournell

Licensed Embalmer No. 4252

P. O. Address Mukerwa

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.