

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027855

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 116 Primary Registration District No. 3020 Registrar's No. 170

FILED JUL 24 1963

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON</u> Length of stay in 1b <u>1 WEEK</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u> c. CITY OR TOWN <u>SULLIVAN</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.R.I</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED First Middle Last <u>WILLIAM LOUIS TIMLIN</u>			4. DATE OF DEATH Month Day Year <u>JULY 21 1963</u>		
5. SEX <u>MALE</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>JULY 9 1940</u>	9. AGE (last birthday) <u>23</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SPOTTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE IND.</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	
13a. FATHER'S NAME <u>JOSEPH TIMLIN</u>		13b. MOTHER'S MAIDEN NAME <u>HELEN SAYER</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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT Address <u>JOSEPH TIMLIN, SULLIVAN, MO. R.R.I</u>
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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>Severe cerebral concussion, chest compression</u> DUE TO (b) <u>fractured rt hip, dislocations left femur</u> DUE TO (c) <u>spinal cord injury</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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		
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
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20c. TIME OF INJURY Hour a.m. p.m. <u>7/13/63</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. CITY, TOWN, OR LOCATION <u>Franklin Co, Mo</u>	20f. COUNTY STATE
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21. I attended the deceased from July 13 63 **to** July 24 63 **and last saw him alive on** July 21 63
 Death occurred at 1:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Washington Mo</u>	22c. DATE SIGNED <u>7/22/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY 23 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY MARTYRS OF JAPAN</u>	23d. LOCATION (City, town, or county) (State) <u>SULLIVAN R.R.I, MO.</u>
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24. FUNERAL DIRECTOR <u>H.M. EATON SULLIVAN, MO.</u>	25. DATE REGD. BY LOCAL REG. <u>7/22/63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED
 VS 300 Rev. 4/59
 10365
 20360
 3
 4 0
 5 0
 6
 7 0
 8 1
 9 X
 10
 11 036
 12 2-0
 13 5-0

AUG 1 1963

AUG 2 1963

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

arrison M. Eaton

Licensed Embalmer No. 4192

P. O. Address Sullivan, 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.