

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-030894**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2100

STATE FILE NUMBER

**FILED JUL 22 1963**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clayton</b>		c. CITY OR TOWN <b>Ferguson</b>	
Length of stay in 1b <b>DOA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>919 Wooster Ave.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Ora</b> Middle <b>R.</b> Last <b>Tindall</b>			4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5-1917</b>	9. AGE (last birthday) <b>46</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Can Co.</b>	11. BIRTHPLACE (City and state or country) <b>Van Wert, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>Ora R. Tindall</b>		13b. MOTHER'S MAIDEN NAME <b>Marie Butler</b>		14. NAME OF HUSBAND OR WIFE <b>Leona G. Tindall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Leona G. Tindall-Ferguson 35, 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>Natural causes, probable coronary</b>		INTERVAL BETWEEN ONSET AND DEATH
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)			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 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 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 \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **6:48 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Raymond [Signature]</i> (Degree or title) <b>Coroner Clayton, Missouri</b>	22b. ADDRESS <b>Clayton, Missouri</b>	22c. DATE SIGNED <b>7/6/63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/3-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>	23d. LOCATION (City, town, or county) <b>Van Wert, Ohio</b>
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24. FUNERAL DIRECTOR <b>White-Mullen Mort.-Ferguson 35, Mo.</b>	ADDRESS <b>118 No. Florissant Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>7-1-63</b>	26. REGISTRAR'S SIGNATURE <i>John B. [Signature]</i>
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DO NOT WRITE ON THIS STUB  
 AMENDED  
 DATE AMENDED  
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 2 4009  
 3  
 4 0  
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 6  
 7 1  
 8 2  
 9 420.1  
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 12 292-3  
 13  
 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

A- SUGGESTION

copy  
100 10

8-90

**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 Reinhold L. Lohman

Licensed Embalmer No. 3395

P. O. Address H. L. 35 110

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.