

LED MAR 11 1943

Registration District No. 220

Primary Registration District No. 5792

1. PLACE OF DEATH:

(a) County Monticau
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Harrison Inn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether

In this community _____ years, months or days)

3. (a) PRINT FULL NAME Fannie May Tindel
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John Tindel 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 24 1865
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Monticau MO
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Modica Yarnell
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name China Standifer
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Derby
(b) Address California
17. (a) Rural (b) Date thereof 1/22/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Yarnell Cem

18. (a) Signature of funeral director William Fredman
(b) Address California mo
19. (a) 1/23/43 (b) Margaret Malone
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monticau
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1943 hour 5 minute 35 P M.
21. I hereby certify that I attended the deceased from Jan 20
1943 to Jan 21 1943
that I last saw him alive on Jan 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Auricular Fibrillation
Duration 2-3 years
1 day

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 938

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. R. Kibbe (M. D. or other) _____
Address California Date signed 1/23/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Not Embalmed*.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.