MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21810

AUG 17 1927

1. PLACE OF DEATH
County: Laclede
Township:
City: Lebanon (No. ..... St. ..... Ward)
Registration District No.: 4449
Primary Registration District No.: 4267
File No.:
Registered No.: ~~1380~~ 1380

2. FULL NAME: Josiah Clarkson Tomlinson
(a) Residence No. Lebanon St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Cornelia Rachel Rval

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 19 1840

7. AGE: 87 YEARS | MONTHS: 4 | DAYS: 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Randolph Co N.C.

PARENTS
10. NAME OF FATHER: Not-Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not-Known
12. MAIDEN NAME OF MOTHER: Not-Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not Known

14. INFORMANT (Address): Lazarus Tomlinson Lebanon Mo

15. FILED 7/24, 1927. J M Billing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 24 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927 to July 24, 1927 that I last saw him alive on July 23, 1927 and that death occurred, on the date stated above, at 7 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Disease Heart
Mitral Regurgitation
92A
95B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 90A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ✓, M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Helena Cemetery
DATE OF BURIAL: July 25 1927

20. UNDERTAKER: Palmer
ADDRESS: Lebanon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

County: Laclede — Registration District No.: 449 — File No.: 21810

Township: — Primary Registration District No.: 4267 — Registered No.:

City: (No.) St. Ward:

2. FULL NAME: Joseph Clarkson Hamlinson

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 11/10/1927 J. M. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 24 1927

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ...m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

...

...

...

...(duration)...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY)

...(duration)...yrs. ...mos. ...ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. M. Billings, M. D.
, 19 (Address) Lebanon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-21810