

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

Do not use this space.

1564615377

1. PLACE OF DEATH
 County St Louis Registration District No. 791
 Township St Louis Primary Registration District No. 1003
 City St Louis (No. Trasco Heights) SL 12 Ward 12
 2. FULL NAME Miss Addie Toland
 (a) Residence, No. 4960 Laclede St., 12 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.

File No. _____
 Registered No. 4608
 SL _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
about 56

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

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

10. NAME OF FATHER Geo. D. Toland

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

12. MAIDEN NAME OF MOTHER Susan Stanford

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

14. INFORMANT C. Starkoff
 (Address) 4960 Laclede

15. FILED 27 APR 1935 May C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-27-1928

17. I HEREBY CERTIFY, That I attended deceased from 4/12/28, 1928, to 4/27/28, 1928, that I last saw her alive on 4/27/28, 1928, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tobacco Pneumonia
100 / 101 W
 (duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (SECONDARY) Pneumonia, unrecalled
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-ray & Physical Exam.
 (Signed) Tratten K. Petersen, M.D.
 , 19 (Address) Frisco Hosp., St Louis

*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 Springfield, Mo. DATE OF BURIAL Apr. 29 1928

20. UNDERTAKER Mullen and Co ADDRESS 5465 Delmar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Full name of informant should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important.

