SEP 27 1928

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

Do not use this space.

1. PLACE OF DEATH
County Stoddard — Registration District No. 837 — File No. 29456
Township Castor — Primary Registration District No. 6099 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Geo Tillman
(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)

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

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

7. AGE: 65 — YEARS — MONTHS ✓ — DAYS ✓ — If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER John Tilman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind
(STATE OR COUNTRY) Dont Know
12. MAIDEN NAME OF MOTHER Tuckers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind
(STATE OR COUNTRY) Dont Know

14. INFORMANT Alex Mooney
(Address) Sufer Co. Home

15. FILED 9-5, 1928 Edward Ford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-5 1928

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1928 to ....., 19.. that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 5 30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebrosc Hemorrage
82A
74A
(duration) yrs. 15 mos. — ds.
CONTRIBUTORY (SECONDARY) Apoplexy
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
X DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) O R Reynolds, 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: Present Hill Cem — DATE OF BURIAL: 8-6 1928

20. UNDERTAKER: J. A. Chiles — ADDRESS: Bloomfield

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.