

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

Do not use this space.

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1. PLACE OF DEATH

County Dade
Township 11
City Arcola, Mo. (No.)

Registration District No. 240
Primary Registration District No. 1-332

File No.
Registered No.
St. Ward)

2. FULL NAME Frankie L. Tolson

(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

MEDICAL CERTIFICATE OF DEATH

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

15. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 23 1930

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

17. I HEREBY CERTIFY, That I attended deceased from 1920 to 1930
that I last saw her alive on Jan 23, 1930, and that death occurred, on the date stated above, at 5 P.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 73 0 13

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 0 13

Cerebral Hemorrhage
82 H
(duration) 3 yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Eastern part of
(STATE OR COUNTRY) Maine

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

10. NAME OF FATHER Otto B. Witham

8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. Higgins, M. D.

12. MAIDEN NAME OF MOTHER Bouant

29-1930 (Address) Arcola, Mo.

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

*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.

14. INFORMANT A. S. Tolson
(Address) Arcola, Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hickory Grove Cem. DATE OF BURIAL Jan-25 1930

15. FILED 2/10 30 A. Higgins REGISTRAR

20. UNDERTAKER J. W. Ward ADDRESS Greenfield

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

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Dade Registration District No. 240 File No. _____
 Township North Primary Registration District No. 5332 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Frankie L. Tolson
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 10, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 | 1 | 13

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (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) _____

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 Jan 10, 1920 A. Higgins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23 1920

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:

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) _____, 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 _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

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at. 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

SUPPLEMENTARY

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