

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

Do not use this space.

17876

1. PLACE OF DEATH

County **St. Francois**

Registration District No. **773**

Township **St. Francois**

Primary Registration District No. **6018A**

File No.

City **Farmington, Mo.**

(No.) St. Ward)

Registered No. **75**

2. FULL NAME Peter Toolen

(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 **Male** 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 **✓**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1870 ? ?**

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

64 ? ?

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Laborer**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

MOTHER 13. NAME **Eugene Toolen**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

15. MAIDEN NAME **Margaret Hunt**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT (ADDRESS) **Hospital Records Farmington, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cemetery** DATE **5-3** 1934

19. UNDERTAKER (ADDRESS) **Del Clark Undertaking Co. 111 Louis Mo.**

20. FILED **May 3** 1934 **J. J. Robinson** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5-1-34**

22. I HEREBY CERTIFY, That I attended deceased from **A-10-34**, to **5-1-34**

I last saw him alive on **5-1-34**, 1934. Death is said to have occurred on the date stated above, at **3:00** p. m.

The principal cause of death and related causes of importance were as follows:

Pneumonia (as) Date of onset

Other contributory causes of importance: **83**

Name of operation **None** Date of **None**

What test confirmed diagnosis? **Allen & Rob** Was there an autopsy? **None**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? **Home** Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify **None**

(Signed) **St. Joseph** M. D.

(Address) **St. Joseph**



St. Francis

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS 17896

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

75-

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Peter Toole

Died at _____ on 5-1-1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 64 Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Where deceased last worked at this occupation: Month _____ Year _____

Place of birth (State or country) _____

Place of birth of father (State or country) _____

Place of birth of mother (State or country) _____

Principal cause of death: Paralysis (A.P.)
General Paralysis of the Insane. (Duetic) 

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar T.L. Robinson

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 773

Primary Reg. Dist. No. 6018 A.

E. T. McGaugh M.D.
Special Agent.

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S-17876 (1934)