

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.

NOV 20 1934

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

Do not use this space.

33128

1. PLACE OF DEATH

46 County Jackson Registration District No. 404  
Township Washington (Primary Registration District No. 5554)  
City Dallas - Mo. (No. Dallas Mo.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. (75)  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Louis D. Tolle  
(a) Residence, No. Dallas Mo. 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-22-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
56 11 8

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

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) Nebraska

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Rose Tolle (ADDRESS) Dallas Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE Oct. 2 1934

19. UNDERTAKER Stine & McClure Und. Co. (ADDRESS) 2235 William Plaza K.C. Mo.

20. FILED 10-5 1934 Geo. P. Dagg Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 30 1934

22. I, Dr. J. P. Dagg, certify that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw him/her live on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above at \_\_\_\_\_ m.

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

Emphysema of the heart

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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

Where did injury occur? Dallas Mo. (Specify city or town, county, and State)

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

Manner of injury Shot in head

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) J. P. Dagg, M. D.

(Address) \_\_\_\_\_

