

JUN 3 1935

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

13867

1. PLACE OF DEATH

County Pettis

Registration District No. 668

Township

Primary Registration District No. 3032

City Sedalia

(No. 1308 So. Ky.

File No. 148

Registered No. 668

St. Ward

2. FULL NAME

James H Toler

(a) Residence, No.

1308 So. Ky.

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)

Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 27 1848

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

86

9

22

OCCUPATION

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

Retired Farmer

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
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

Florence

Mo

FATHER

13. NAME Jessie O Toler

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

Ky

MOTHER

15. MAIDEN NAME Sarah Ann Bowls

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

Mo.

17. INFORMANT
(ADDRESS)

Mrs. Geo Croll

Lamonte Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Antioch

DATE Apr. 21 35

19. UNDERTAKER
(ADDRESS)

Gillespie Funeral Home

Sedalia Mo

20. FILED

4-21-1935 Jean Slack

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 19 1935

22. I HEREBY CERTIFY, That I attended deceased from

the body, 19, to April 20, 1935

I last saw him alive on 7-30, 19. Death is said

to have occurred on the date stated above, at 7:30 p.m.

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

Apoplexy

Date of onset

Other contributory causes of importance:

Arterio Sclerosis
Nephritis

Name of operation

Date of

What test confirmed diagnosis? Was there an autopsy? No

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?
(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

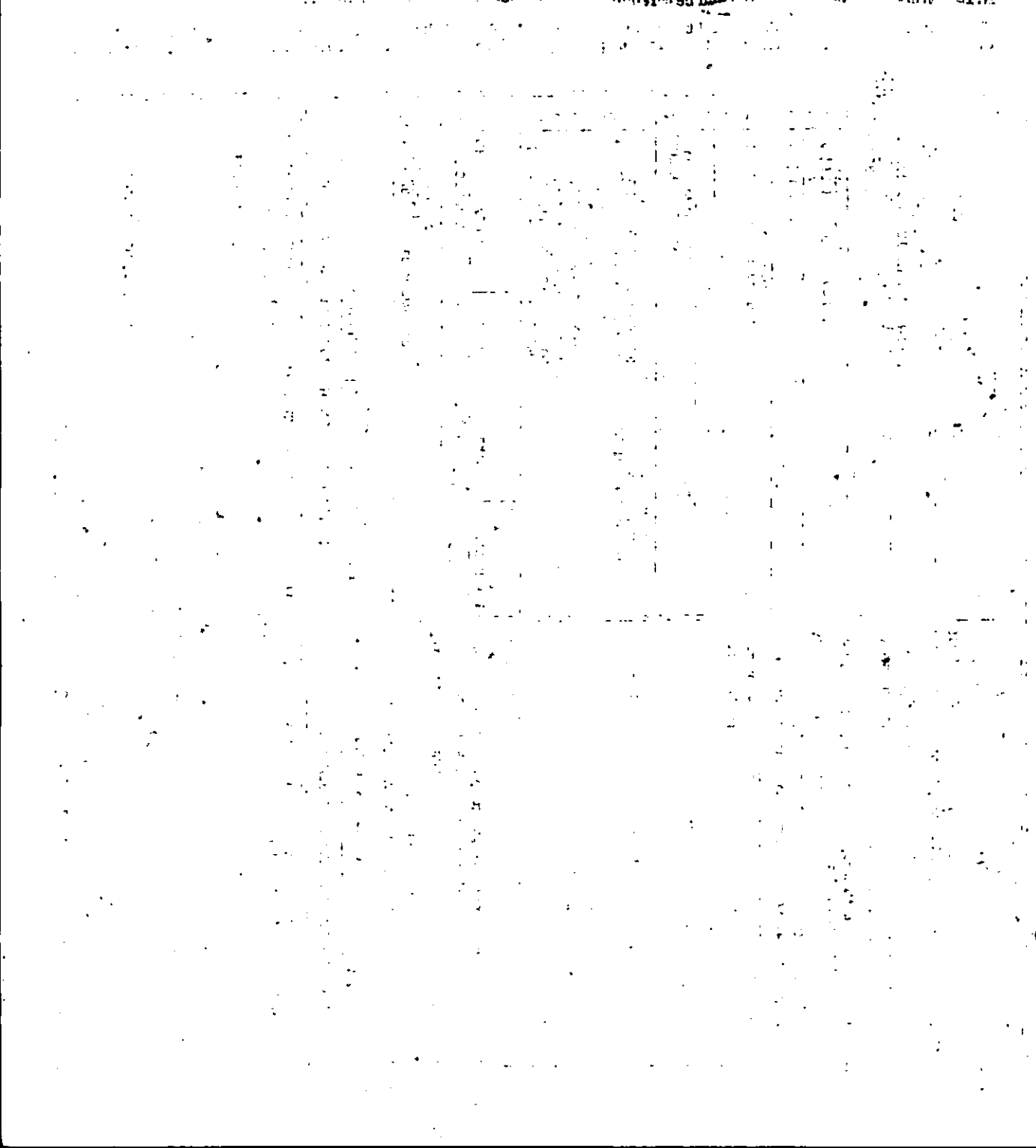
24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pettis
Township Sedalia
City Sedalia (No. _____)

Registration District No. 668
Primary Registration District No. 3032

File No. _____
Registered No. 144
St. _____ Ward _____

2. FULL NAME

James H. Toler

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 9 22

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

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED 4-22-1935 Dean Slack Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 19 1935

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him alive 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:

apoplexy Date of onset _____

Other contributory causes of importance:

arteriosclerosis
hypertension
chronic

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 _____, 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 _____

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

If so, specify _____

(Signed) _____, M. D.

(Address) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

Every item of information on this form is 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.

JUN 15 1935

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