

Registration District No. **502**

Primary Registration District No. **4305**

Registrar's No. **29**

**1. PLACE OF DEATH:** **2**  
 (a) County **Lincoln**  
 (b) City or town **Marceline**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **None**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **no**  
 In this community **Still Birth** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County **1**  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

**3. (a) PRINT FULL NAME** **Stillborn Toivola**  
**8. (b) If veteran, name war** \_\_\_\_\_ **8. (c) Social Security No.** \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Oct** day **29**  
 year **1934** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

**4. Sex** **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** \_\_\_\_\_  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** **Oct 29 1934**  
 (Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Still Birth**  
 Due to \_\_\_\_\_  
 Due to **No Evidence**

**9. Birthplace** **Marceline Mo**  
 (City, town, or county) (State or foreign country)

Other conditions **In Utero**  
 (Include pregnancy within 3 months of death)

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_  
**12. Name** **Deivid R. Louheva**  
**13. Birthplace** **Marceline Mo**  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** **Marceline Valtti**  
**15. Birthplace** **Marceline Mo**  
 (City, town, or county) (State or foreign country)

**PHYSICIAN**  
 Major findings: **None**  
 Of operations \_\_\_\_\_  
 Of autopsy **None**  
 Underline the cause to which death should be charged statistically

**16. (a) Informant's signature** **P. J. Pateneck**  
**(b) Address** **Marceline Mo**  
**17. (a) Burial, cremation, or removal** **Burial** **(b) Date thereon** **Oct 29-34**  
 (Month) (Day) (Year)  
**(c) Place: burial or cremation** **St. Olivet**

**22. If death was due to external causes, fill in the following:**  
**(a) Accident, suicide, or homicide (specify)** **None**  
**(b) Date of occurrence** \_\_\_\_\_  
**(c) Where did injury occur?** \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
**(d) Did injury occur in or about home, on farm, in industrial place, in public place?** \_\_\_\_\_

**18. (a) Signature of funeral director** **Jos. M. Bayliss**  
**(b) Address** **Marceline Mo**  
**19. (a) 10-25** **(b) Clair F. Barrett**  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
**23. Signature** **P. J. Pateneck** (M. D. or other) \_\_\_\_\_  
**Address** **Marceline Mo** Date signed **10/29/34**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

District No. 11,  
State of Ohio 1139-1229  
Date filed NOV-16-1939

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**