

FILED MAR 5 - 1940

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

8394

Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 845  
 (b) Township Ruth Primary Registration District No. 6108 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. 9 How long in U. S., if of foreign birth? yrs. mos. ds. \_\_\_\_\_

2. PRINT FULL NAME Nancy J. Tolbert  
 (a) Residence, No. New Reed Spring Mo St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF John Tolbert (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
 7. AGE YEARS 82 MONTHS 17 DAYS 17 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Widow  
 9. Industry or business in which work was done, as 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) Mo13. NAME Steve Perkins14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dartmouth15. MAIDEN NAME Mary J. Hembree16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo17. INFORMANT (ADDRESS) Mrs. Tom Tilton18. BURIAL, CREMATION, OR REMOVAL PL. Green Pond Cem DATE Feb 19 4019. FUNERAL DIRECTOR (NAME) (ADDRESS) Ward20. FILED 2/29/40 L. S. Skumate Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 17 194022. I HEREBY CERTIFY That I attended deceased from Feb. 10 1940 to Feb 17 1940I last saw him alive on Feb 17 1940 Death is saidto have occurred on the date stated above, at 2 P. m.

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

Chronic Bronchitis

Date of onset

1935

Other contributory causes of importance:

Hydrothorax

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) Reed Spring Mo

RECEIVED

District Health Officer No. 6,

District File Number 940-615

Date Filed MAR 4 1940

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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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **8394**

Registration District No. **845**

Primary Registration District No. **6108**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County **St. Louis**  
(b) City or town **Ruth T. P.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(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

**Nancy J. Tolbert**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased **Jan 31 1885**  
(Month) (Day) (Year)

8. AGE: Years **82** Months \_\_\_\_\_ Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) **Feb 17 1940** (b) **R. S. Skumate**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb** day **17**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **L. S. Skumate** (M.D. or other) \_\_\_\_\_  
Address **Ruth Springs** Date signed \_\_\_\_\_

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

SUPPLEMENTAL

