

APR 8 1940  
Registration District No. \_\_\_\_\_

Primary Registration District No. 4438

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Huntsville  
(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 4 25

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Huntsville  
(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 JOHN TOLSON

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

4. Sex M 5. Color or race Black 6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased Jan 15 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 / 1 / 28 hr. min.

9. Birthplace Chariton County  
(City, town, or county) (State or foreign country)

10. Usual occupation Coal miner

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Tom Tolson

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Wing Cramer

15. Birthplace Blatt County (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Luella Tolson

(b) Address Huntsville

17. (a) Burial (b) Date thereof Mar 17, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntsville

18. (a) Signature of funeral director Tom B. Patton

(b) Address Huntsville, MO

19. (a) Apr - 1 - 1940 (b) Mrs. D. A. Barnhart  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13  
year 1940 hour 11 minute 05 M.

21. I hereby certify that I attended the deceased from Dec 5, 1939, to Mar 11, 1940

that I last saw him alive on Mar 11, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis Duration 3 months

Due to Bright's Disease

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

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

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

Of autopsy none

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? Yes

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

23. Signature P. V. Dreyer M.D. (M. D. or other) \_\_\_\_\_

Address Huntsville MO Date signed 3/27/40

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.

972

RECEIVED

District Health Officer No. 10

District File Number 4-40-740

Date Filed APR 2 1940

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 Paul J. Patton

Licensed Embalmer No. 4095

P. O. Address Huntsville, Mo

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. 12121

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 133

Primary Registration District No. 4438

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

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

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Mountville  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

John Toolson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. C

4. Sex m

5. Color or race col

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years 68

Months 1

Days 28

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

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

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) \_\_\_\_\_

(Date received local registrar)

(Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13  
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 Chronic Myocarditis

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

Due to Chronic Brights Disease

Other conditions due to certain relations  
(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 P. V. Dreyer (M. D. or other) \_\_\_\_\_

Address Mountville Date issued \_\_\_\_\_

SUPPLEMENTARY

1940  
S-12121