

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

25514

State File No. \_\_\_\_\_

Registration District No. 431

Primary Registration District No. 3023

Registrar's No. 83

1. PLACE OF DEATH:  
 (a) County Johnson  
 (b) City or town Warrensburg  
 (c) Name of hospital or institution:  
110 E. Russell  
 (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 Missouri (b) County Johnson  
 (c) City or town Warrensburg, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 110 E. Russell  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Amanda Tobias 120  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 3  
 year 1940 hour \_\_\_\_\_ minute 10 A. M.

4. Sex Fe 5. Color or race Wh.  
 6. (a) Single, widowed, married, divorced, Married  
 6. (b) Name of husband or wife John T. Tobias  
 6. (c) Age of husband or wife if alive 73 years  
 7. Birth date of deceased July 7 1869  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1, 1940 to July 3, 1940  
 that I last saw him alive on July 3, 1940  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_  
Pulmonary edema

8. AGE: Years 70 Months 11 Days 26 hr. \_\_\_\_\_ min. \_\_\_\_\_  
 If less than one day

Due to congested heart failure  
 Due to \_\_\_\_\_

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

Other conditions Tumor of stomach  
 (include pregnancy within 3 months of death)  
& malignancy.

10. Usual occupation housewife

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy 46

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

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

16. (a) Informant's own signature Emma Nauale  
 (b) Address 424 S. Oakley Blvd. Chicago  
 17. (a) Burial (b) Date thereof July 5 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Pisgah Cem. Johnson Co. Mo.  
 18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address Warrensburg Mo.  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

23. Signature Samuel Harkness M. D. co-signer  
 Address Warrensburg, Mo. Date signed 7/4/40

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 8-7-40

**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..... *Donald W. Taplin*  
Licensed Embalmer No. *3053*  
P. O. Address *Warrensburg 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. 25-8-14

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 1/31

Primary Registration District No. 3023

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

1. PLACE OF DEATH

(a) County Johnson  
(b) City or town Warrensburg  
(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)

3. (a) PRINT FULL NAME Amanda Tobias

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 no

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 Months Days If less than one day  
70 11 26 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 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

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

19. (a) Sept. 7, '40 (b) Delate Anson, Reg. (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 7 day 3  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration of illness: \_\_\_\_\_  
Cause of death: \_\_\_\_\_

Pulmonary congestion  
congestive heart failure  
liver  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)

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

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) (c) Means of injury \_\_\_\_\_

23. Signature Harry Harkness (M.D. or other)  
Address Warrensburg Date signed \_\_\_\_\_

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

SUPPLEMENTAL

