

FILED SEP 24 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29783

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

795-6038

76

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Grand Pass
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Jahn W. Tolla 400

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

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

6. (b) Name of husband or wife Alice Agard Tolla 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 1-1-1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Hillsboro Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Shannon Tolla

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

14. Maiden name Judy Ann McElae

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

16. (a) Informant Mrs Arthur McReynolds

(b) Address Kansas City Mo

17. (a) Burial (b) Date thereof 8-27-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Grand Pass Cemetery

18. (a) Signature of funeral director Willis Marshall

(b) Address Cassette Mo

19. (a) 9-10-40 (b) Raymond Spiver
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Grand Pass
(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 8 day 26
year 1940 hour _____ minute 4:45 A. M.

21. I hereby certify that I attended the deceased from 8-17-1940 19 _____ to 8-25 1940
that I last saw him alive on 8-25 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatative Heart

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

713 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Geo. S Jones (M. D. or other) _____

Address Warrens, Mo Date signed 8/26/40

Duration

PHYSICIAN

Underlines the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number. 9-11-40
Date Filed

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 ML

....., Registered Apprentice No. me
working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton 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.