

JAN 20 1941

Registration District No. 333

Primary Registration District No. 5713

Registrar's No.

79

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Hudson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Infirmary
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Macon
(c) City or town Hudson Twp
(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

Frank Tolery

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

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 _____

7. Birth date of deceased _____
(Month) 1860 (Day) (Year)

8. AGE: Years 80 Months _____ Days _____
If less than one day _____ hr. _____ min.

9. Birthplace Don't know
(City, town, or county) (State or foreign country)

10. Usual occupation _____

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 Wm Passey

(b) Address RR Macon Mo

17. (a) burial (b) Date thereof 1/14/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Robert Skinner

(b) Address Macon Mo

19. (a) 1/6/41 (b) Robert Skinner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30
year 1940 hour 7 minute P M.

21. I hereby certify that I attended the deceased from Feb, 1932, to Dec 30, 1940
that I last saw him alive on Dec 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction 10 days

Due to umbilical hernia unknown

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Arterio-sclerosis

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? _____

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

23. Signature J J Turner (M. D. or other) _____

Address Macon Mo Date signed 1/3/41

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

2
-40
-39
23158

RECEIVED

District Health Officer No. 10

Case File Number 1-41-132

Date Filed JAN 10 1941

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

Ernest P. Hill

Licensed Embalmer No. 4066

P. O. Address

Mason, Miss.

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, fact should be so stated above.