

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **6105**  
Registrar's No. **69**

Registration District No. **1** Primary Registration District No. **1**

1. PLACE OF DEATH **Adair**  
(a) County **Adair**  
(b) City or town **Kirksville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1315 North Elson Street /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **60vr.** (Specify whether  
in this community years, months or days)

3. (a) PRINT FULL NAME **Laura Etta Toney**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **female** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **widow**  
6. (b) Name of husband or wife **Clint Toney** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Sept. 21 1865**  
(Month) (Day) (Year)

8. AGE: Years **75** Months **5** Days **7** If less than one day hr. \_\_\_\_\_ min.

9. Birthplace **Appanoose Co. / Iowa**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **at home**  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **William Ellis**  
13. Birthplace **Indiana**  
14. Maiden name **Margrett Thompson**  
15. Birthplace **Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Howard Toney**  
(b) Address **1315 N. Elson St. Kirksville**  
17. (a) **burial** (b) Date thereof **March 2-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **New Harmony Cemt.**  
18. (a) Signature of funeral director **Laura Riley**  
(b) Address **Kirksville Mo**  
19. (a) **B-6-41** (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Adair**  
(c) City or town **Kirksville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1315 North Elston**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **February** day **28**  
year **1941** hour **10** minute **30** M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw her on **Feb 28**, 19**41**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Supposed**  
**Pneumonia as**  
**patient was dead when**  
Due to **she was called**  
Duration \_\_\_\_\_  
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?  
3 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **L. J. Comer** (M. D. or other) \_\_\_\_\_  
Address **Kirksville Mo** Date signed **5/3/41**

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

104

**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.....

000 11107

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Doc Riley*

Licensed Embalmer No. 4181

P. O. Address: Kirksville 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, fact should be so stated above.**

No. 2B  
-21-40  
X22599

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 6105-

Registration District No. 1

Primary Registration District No. 1

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

1. PLACE OF DEATH:

(a) County Adair  
(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 Laura Etta Joney  
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 \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)  
8. AGE: Years 75 Months 5 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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)  
(Burial, cremation, or removal)

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

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

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

19. (a) May 3, 1941 (b) Spencer L. Freeman  
(Date received at 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 Feb day 28  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Bronchial pneumonia

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? \_\_\_\_\_

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

23. Signature L. Conner (M. D. or other) \_\_\_\_\_

Address Warrensburg Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

S-6105