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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24681

ition District No. 104 Primary Registration District No. 3008 Registrar's No. 200

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

1. PLACE OF DEATH:
(a) County Calloway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or Institution 2 yrs 1 mo (Specify whether years, months or days)
In this community 19 days

2. USUAL RESIDENCE OF DECEASED: 014
(a) State Missouri (b) County Cole
(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")
(d) Street No. 113 Adams St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME CATHERINE TOLIN
3. (b) If veteran, name war
3. (c) Social Security No. none
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Jesse B. Tolin
6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased Dec. (Month) 12 (Day) 1863 (Year)
8. AGE: Years 77 Months 07 Days 15 If less than one day hr. min.
9. Birthplace Cooper County (City, town, or county) U (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name John Curran
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
14. Maiden name Kate Clifford
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
16. (a) Informant Hospital Records
(b) Address State Hospital #1
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Jefferson City Mo
18. (a) Signature of funeral director Thos J Gordon
(b) Address Jefferson City Mo.
19. (a) 7-27-41 (Date received local registrar) (b) R. N. Crews (Registrar's signature)
106 (Licensed Embalmer's Statement on Reverse Side) Sutton

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1941 hour minute 10 A. M.
21. I hereby certify that I attended the deceased from April 5, 1941, to July 27, 1941; that I last saw her alive on July 26, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar pneumonia	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Katherine Shirley (M. D. or other) M.D.
Address State Hospital #1 Date signed 7-27-41

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 Fred P Dulle, Registered Apprentice No. ..... working under my personal supervision.

Signed Fred P Dulle

Licensed Embalmer No. 3890

P. O. Address Jefferson City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24 681

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 200

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Catherine Solin
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 ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)
8. AGE: Years | Months | Days | 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) Removal (Burial, cremation, or removal) (b) Date thereof July 27, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) Sept. 13, 1941 (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
year 1941 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.

	Duration
Immediate cause of death	
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)
(b) 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 .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....