

FILED OCT 10 1941

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Hospital 7 Days
 (Specify whether
 In this community 76 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2327 So. 9th. St.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Louis Toothman
 3. (b) If veteran, name war _____
 3. (c) Social Security No. none

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: June 16 1865
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>3</u>	<u>2</u>	hr. _____ min.

9. Birthplace Halls Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Section Labor

11. Industry or business Railway

MOTHER FATHER {
 12. Name Russell Toothman
 13. Birthplace Unknown Indiana
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Edward Toothman
 (b) Address 2329 So. 9th. St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 9/20/41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Walter Meerschhoff

(b) Address 1302 Faraon, St. St. Joseph, Mo.

19. (a) 9-20-1941 (b) H. J. Nestle
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18
 year 1941 hour 8 minute 30 AM.

21. I hereby certify that I attended the deceased from 9-8-41
 _____, 19____ to 9-18-41, 19____
 that I last saw him alive on 9-18-41, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Hypertension
Chronic Nephritis

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)
 Means of injury _____
 23. Signature Dr. W. H. Gray (M. D. or other) MO
 Address Rickpatnick Bldg Date signed 9-17-41

ST. JOSEPH

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

Dr. Craig

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 *Oby Jester*
Licensed Embalmer No. *Mo. 4154*

P. O. Address *St. Joseph, 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.