

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4730**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
248  
3  
8

**1. PLACE OF DEATH:**

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3509 Paseo**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **Unknown** years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Jackson** **048**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3509 Paseo**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRINT FULL NAME **Harvey McClellan Tollinger**

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

4. Sex. **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Della** 6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **Aug. 8 1862**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **4** Days **10** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **York Penn.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business \_\_\_\_\_

12. Name **Albert T. Tollinger** Penn. **1**  
(City, town, or county) (State or foreign country)

13. Birthplace \_\_\_\_\_ Penn. **1**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Douglas** Penn. **1**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edgar Cawthorn**  
(b) Address **Eldon, Missouri**

17. (a) **Burial** (b) Date thereof **12-20-1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Eldon Cemetery**

18. (a) Signature of funeral director **Phillips Funeral Home**

(b) Address **Eldon, Missouri**

19. (a) **12-19-41** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **December** day **17** 19**41** year. hour **4** minute **45** A.M.

21. I hereby certify that I attended the deceased from **12-3-41** 19 to **12-17-41** 19; that I last saw him alive on **12-17-41** 19; and that death occurred on the date and hour stated above.

Immediate cause of death **Heart Failure.**

Due to **Arterio-Sclerosis.**

Other conditions **Cerebral Arterio-Sclerosis, senility.**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy **no**

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 **M. M. Brown** (M. D. or other) \_\_\_\_\_  
Address **522 Professional Bldg. Kansas City, Mo** Date signed **12-19-41**

Duration

**Chronic**

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

..... Louis D. Phillips ....., Registered Apprentice No.....  
working under my personal supervision.

Signed Louis D. Phillips  
Licensed Embalmer No. 3663

P. O. Address Eldon

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4730

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(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.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Harvey Mc. b Sollinger

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

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

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 79 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)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) March 30 1942 (Date received local registrar) M. H. Crowe (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.

20. DATE OF DEATH: Month Dec day 17 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.

Immediate cause of death Chronic fibrous myocarditis  
Arteriosclerosis

Due to.....  
Other conditions Cerebral Arteriosclerosis  
(Include pregnancy within 3 months of death)  
Senility

Major findings: 93d  
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?.....

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

23. Signature Chas. Harding (M. D. or other)  
Address 522 Professional Bldg  
K.C. Mo Date signed 3/28/42

SUPPLEMENTAL

S-41050