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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21597

Registration District No. FILED JUN 22 1948

Primary Registration District No. 2000

Registrar's No. 481

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days (Specify whether
In this community 16 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 55

(a) State Missouri (b) County Lawerence

(c) City or town Mt Vernon Rural
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? — no (Yes or No)

If yes, name country — —

3. (a) PRINT FULL NAME Tolliver, Jacob Henry

3. (b) If veteran, name war UNK

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Tolliver

(c) Age of husband or wife if alive 6 years

7. Birth date of deceased 6 (Month) — 4 (Day) — 1879 (Year)

8. AGE: Years 65 Months 0 Days 3 If less than one day hr. min.

9. Birthplace Mount Vernon (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Jonathan Tolliver
13. Birthplace Mount Vernon (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Isabel Samuels
15. Birthplace Mount Vernon (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Wife, Mrs. J.H. Tolliver

(b) Address Mount Vernon, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-7-1944 (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Cemetery

18. (a) Signature of funeral director H. D. Fassett

(b) Address Mt. Vernon Mo

19. (a) 6-13-44 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 7 year 1944 hour 9 minute 02 P.M.

21. I hereby certify that I attended the deceased from May 27, 1944, to June 6, 1944, that I last saw him alive on June 6, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Degenerative Heart Disease	2yr.
Due to Left Ventricular failure	4 WKS.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

934

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 H. P. Maddux (M.D. or other)

Address Springfield, Mo. Date signed 6-13-44

(Licensed Embalmer's Statement on Reverse Side)

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 H. W. Fossett

Licensed Embalmer No. 2201

P. O. Address Mt. Vernon N

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.