

FILED AUG 8 1944
Registration District No. 318

Primary Registration District No. 1003

State File No. _____

Registrar's No. 6612

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Park Lane Hospital
(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 Theron O. Tozier

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Agnes Tozier

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Sept 22 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>10</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman

11. Industry or business Grace Sign Co.

MOTHER FATHER { 12. Name Waldo Tozier

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Mixon

15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Agnes Tozier

(b) Address 4686 Tennessee Ave.

17. (a) Burial (b) Date thereof 7-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cem.

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) JUL 28 1944 J. B. Branch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 19

(c) City or town St. Louis 9 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4686 Tennessee Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27th
year 1944 hour 12 minute 20 AM

21. I hereby certify that I attended the deceased from July 16 to July 27, 1944, to July 28, 1944, that I last saw him alive on July 28, 1944 and that death occurred on the 28 and hour stated above.

Immediate cause of death: Cerebral hemorrhage Duration 24 hrs

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? _____

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

23. Signature Clyde E. Kane (M. D. or other) MD
Address 706 Walnut Date signed 7/27/44

1914

Warren Carver
706 Walton
Co 1686 10-12

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 Warren A. Carver
Licensed Embalmer No. 3534
P. O. Address.....

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.