S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1945

Registration District No. 1

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 40-2-5033

State File No. 12689

Registrar's No.

1. PLACE OF DEATH:

(a) County: Audrain

(b) City or town: Martinsburg Mo; Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home

(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: 27 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Audrain

(c) City or town: Martinsburg Mo. Rural
(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

3. (a) PRINT FULL NAME: Minnie Tolts

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Female

5. Color or race: W.

6. (a) Single, widowed, married, divorced: ✓

6. (b) Name of husband or wife: Joseph Tolts

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

7. Birth date of deceased: Jan (Month) 6 (Day) 1893 (Year)

8. AGE: Years 51 Months 8 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace: Lincoln Co Mo (City, town, or county) ..... (State or foreign country)

10. Usual occupation: House Wife

11. Industry or business: Home

FATHER
12. Name: Frank Stingel
13. Birthplace: Bohemia (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name: Mary Martinek
15. Birthplace: Mabhek Mo. (City, town, or country) ..... (State or foreign country)

16. (a) Informant: John Stingel
(b) Address: Laurel Bend Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/3/45 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Martinsburg Mo

18. (a) Signature of funeral director: R. B. Wells
(b) Address: Wellsville Mo.

19. (a) 3/3/45 (Date received by local registrar) (b) Mary C. Jacobs (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st year 1945 hour 4 minute 2 P. 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: Injuries from being struck by Ford Coupe, By Accident caused by upset of automobile and

Due to: Wabash passenger Train #2 Engine #203 on March 1st

Due to: 1946 About 1:45 P. M. in the City of Martinsburg Mo.

Other conditions: Jury & Coroner
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations: No

Of autopsy: No

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): Accident

(b) Date of occurrence: 3/1/45

(c) Where did injury occur? Martinsburg Audrain Co (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)

While at work? No (e) Means of injury: Violence

23. Signature: L. C. Adams Coroner (M. D. or other)

Address: Mexico Mo Date signed: 3/3/45

1941

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 40-45-710
Date Filed APR 1 3 1945

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~~ Self.

....., Registered Apprentice No.....,

working under my personal supervision.

Signed T. B. Kelly

Licensed Embalmer No. 1588

P. O. Address Kellville. Mo

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 7 Primary Registration District No. 5033 Registrar's No. 9

1. PLACE OF DEATH:

(a) County Andrain

(b) City or town Rural Laurie Twp
(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 (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 Minnie Falta

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 (married)

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Jan (Month) 6 (Day) 1893 (Year)

8. AGE: Years 51 Months 8 Days 23 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Mary C. Jacobs (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day year 1943 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 — Duration

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

12689