M—5-43
5-17-39
I X36671

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. 21575

FILED JUL 12 1945

Registration District No. 3060 Primary Registration District No. 3076 Registrar's No. 75

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: 331 N Ash 1
(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)

2. USUAL RESIDENCE OF DECEASED: 108

(a) State Missouri (b) County Vernon 1

(c) City or town Nevada 1
(If outside city or town limits, write "RURAL")

(d) Street No. 331 N. Ash Street 2
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Isabelle J. Tolle

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

4. Sex Fm 1 5. Color or race W 6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2

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

7. Birth date of deceased November (Month) 28 (Day) 1849 (Year)

8. AGE: Years 95 Months 6 Days 22 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

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

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

16. (a) Informant G. H. Summers
(b) Address Nevada, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Richards Cemetery

18. (a) Signature of funeral director Terry Funeral Home
(b) Address Nevada, Mo.

19. (a) 6-20-45 (Date received local registrar) (b) Hazel B. Beneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19 year 1945 hour 7 minute 30 A M.

21. I hereby certify that I attended the deceased from 9-24-44, to 9-24-44, that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senility	
Due to	
Due to	
Other conditions Inguinal hip 1944 (Include pregnancy within 3 months of death)	

Major findings: Of operations None

Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 [signature] 0 (M. D. or other)

Address Nevada, Mo. Date signed 6-20-45

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 6-43-649
Date Filed 9-11-45

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 Me

, Registered Apprentice No.

working under my personal supervision.

Signed L B Terry

Licensed Embalmer No. 1960

P. O. Address Nevada, 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, fact should be so stated above.

No. 2B
4—3-45
1 X43880

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. July

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 71-d

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Nevada
(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 Isabelle J. Tolle
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Mar. 28 (Month) (Day) (Year)
8. AGE: Years 95 Months 6 Days 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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 9 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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) Inguinal hernia
(b) Date of occurrence Sept 24-1944
(c) Where did injury occur? In home (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? No (e) Means of injury Fall
23. Signature (M. D. or other)
Address Date signed 7-14-45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

21575