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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1946

Registration District No. 6

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24966

Primary Registration District No. 6076

Registrar's No. 1433.

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 98 DAYS (Specify whether years, months or days)

In this community 98 DAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County —

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 5N 9th ST.
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME RICHARD CLAY TOLAND

3. (b) If veteran, name war

3. (c) Social Security No. 527-06-6768

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife —

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

7. Birth date of deceased 6 (Month) 8 (Day) 1903 (Year)

8. AGE: Years 43 Months 1 Days 11 If less than one day hr. min.

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

10. Usual occupation COOK

11. Industry or business —

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

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

16. (a) Informant HOSPITAL RECORD

(b) Address KOCH HOSP., KOCH, MO.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 8-2-46 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) AUG 5 1946 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19 year 1946 hour 9 minute 26 P. M.

21. I hereby certify that I attended the deceased from 4/12, 1946, to 7/19, 1946, that I last saw him alive on 7/19, 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: PULMONARY TUBERCULOSIS	? YEARS
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 David Feldman M.D. (or other) MD

Address Koch Hosp., Koch, Mo. Date signed 7/29/46.

(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.....

Licensed Embalmer No.....

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.