

Registration District No.

372

Primary Registration District No.

4543

Registrar's No.

25

1. PLACE OF DEATH:

(a) County WEBSTER
 (b) City or town Seymour
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3
 (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

WILLARD TOOLEY

3. (b) If veteran,

name war

3. (c) Social Security

No. 496-03-90784. Sex MALE5. Color or race WHITE6. (a) Single, widowed, married
divorced MARRIED6. (b) Name of husband or wife LORENA

6. (c) Age of husband or wife if

LOTTalive 24 years

7. Birth date of deceased

APRIL22 1910

8. AGE:

Years

Months

Days

If less than one day

36613

hr.

min.

9. Birthplace

DODDGLAS COUNTY

(City, town, or county)

17

(State or foreign country)

10. Usual occupation

LABOR

11. Industry or business

INDUSTRY

12. Name

TANDY D. TOOLEY

13. Birthplace

INDIANA

(City, town, or county)

(State or foreign country)

14. Maiden name

NORA A. KNIGHT

15. Birthplace

ILLINOIS

(City, town, or county)

(State or foreign country)

16. (a) Informant

(FATHER) TANDY D. TOOLEY

(b) Address

MTN. GROVE MO.17. (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof

NOV. 19 1946

(Month) (Day) (Year)

(c) Place: burial or cremation

VANZANT MO.

18. (a) Signature of funeral director

J. W. Barber

(b) Address

Mtn. Grove, Mo.19. (a) Nov 18-46

(Date received local registrar)

(b)

Gilbert Jones

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GREEN 39
 (c) City or town SPRINGFIELD, MO. 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. 848 SOUTH WEAVER 6
 (If rural, give location)
 (e) Citizen of foreign country? NO. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 16
 year 1946 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 Skull Fracture
broken neck

Duration

Due to Automobile Collision

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) Accident 1/2
 (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 323. Signature J. J. Kelley coroner

(M. D. or other)

Address Hardland MoDate signed 11-18-46

RECEIVED

District Health Officer No. 6,

District File Number 1146-1160

Date Filed NOV 27 1946

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. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Garland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See

Registration District No. 872

Primary Registration District No. 4543

Registrar's No. 25

1. PLACE OF DEATH:

- (a) County Webster
 (b) City or town Seymour mo.
 (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

In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Willard Zooley

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased April 22 1946
 (Month) (Day) (Year)

8. AGE: Years 36 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Gilbert Jones
 (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 year 1946 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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

39455