

Registration District No. \_\_\_\_\_ Primary Registration District No. **3009**

1. PLACE OF DEATH:  
(a) County Cape Girardeau  
(b) City or town Jackson mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
217 1/2 1st West St. 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:  
(a) State Missouri (b) County Cape Girardeau  
(c) City or town Jackson  
(If outside city or town limits, write "RURAL")  
(d) Street No. 217 1/2 1st West St.  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jacob F. TOELKEN  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 25th  
year 1947 hour 9:00 minute 9 A.M.

4. Sex MO 5. Color or race: W  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Martha Toelken 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased: March 17 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 22nd 1940 to April 25th 1947;  
that I last saw him alive on April 25th 1947,  
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 1 Days 8  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Congestive Heart Failure  
Due to Cardio-Vascular Disease

9. Birthplace Chapin Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Farmer

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: CHF  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Herman Toelken  
13. Birthplace Chapin Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Sophia Gimmern  
15. Birthplace Chapin Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. F. Toelken  
(b) Address Jackson mo  
17. (a) Burial (b) Date thereof 4/28/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation city cemetery  
18. (a) Signature of funeral director McComb & Co.  
(b) Address Jackson mo  
19. (a) 4-26-47 (b) 25. G. Dierker  
(Date received local registrar) (Registrar's signature) 42

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? 2  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature W. H. Lindall (M. D. or other) DO  
Address Jackson, Mo. Date signed 4/26/47

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

RECEIVED

Health Officer No. 4

447-603

4-30-47

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**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..... *BA Meyer*

Licensed Embalmer No. 3057

P. O. Address..... *Jackson 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.**