

FILED DEC 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40484

State File No.

BIRTH NO. 81234-49 REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 3011 Registrar's No. 106

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>	c. LENGTH OF STAY (in this place) <u>4 hrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Waverly Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>South side Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print) <u>KATHLEN</u>			a. (First)	b. (Middle)	c. (Last) <u>TOLLIVER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 4 1949</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>		8. DATE OF BIRTH <u>Dec. 4, 1949</u>		9. AGE (in years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Griffie Tolliver</u>		13b. MOTHER'S MAIDEN NAME <u>Jacqueline Folt Owen's</u>		14. NAME OF HUSBAND OR WIFE <u>Child</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Child</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Griffie Tolliver</u> ADDRESS <u>Waverly Mo.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Potent Foramen ovale</u>		DUE TO (b) _____				7542	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from ON 12/4, 1949 to _____, 19____, that I last saw the deceased alive on 12/4, 1949, and that death occurred at 8 AM., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>Waverly</u>		23c. DATE SIGNED <u>12/4/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-4-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Christian Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Lincoln Mo.</u>	

DATE REC'D BY LOCAL REG. <u>12/4/49</u>		REGISTRAR'S SIGNATURE <u>Mrs Herbert Calves</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall Funeral Home</u> ADDRESS <u>Carrollton Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED DEC 12
District Health Officer No. 87

District File Number _____

Date Filed 12-20-49

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 _____

This child was placed in a fluid pack.

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed *R. M. Marshall*

Licensed Embalmer No. 2525

P. O. Address *Carrollton 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.