

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1398**

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BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. LENGTH OF STAY (In this place) 3 wks		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Mo.		12/8	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Regis Hotel				d. STREET ADDRESS (If rural, give location) Linwood & Paseo St. Regis			
3. NAME OF DECEASED (Type or Print) a. (First) DONALD		b. (Middle) WAYNE		c. (Last) TOLIVER		4. DATE OF DEATH (Month) (Day) (Year) 1/6/50	
5. SEX Male		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 1/7/43	
9. AGE (In years last birthday) 6 yrs		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Leavenworth, Kans.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Harry C. Toliver		13b. MOTHER'S MAIDEN NAME Marian Behel		14. NAME OF HUSBAND OR WIFE Harry C. Toliver, Kans.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Harry C. Toliver		ADDRESS Linwood & Paseo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hyperplasia of gland- iatryphal lymphatics DUE TO (c) Lymphatic leukemia				INTERVAL BETWEEN ONSET AND DEATH. 30 min 6 mo 6 mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 2040				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) m.		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 12-30, 1949 to 1-6, 1950 , that I last saw the deceased alive on 1-5, 1950 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE E. D. Reese D.O. (Degree or title)				23b. ADDRESS 3309 E. 12		23c. DATE SIGNED 1-6-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/7/50		24c. NAME OF CEMETERY OR CREMATORY Leavenworth, Kans.		24d. LOCATION (City, town, or county) (State) Leavenworth, Kans.	
DATE REC'D BY LOCAL REG. 1-7-50		REGISTRAR'S SIGNATURE S. Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil, K. C. Mo. ADDRESS			

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

Dr. Reese
3309 E 12th

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

John P. Sheel

Licensed Embalmer No. 8625

P. O. Address KB 40

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.