

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42937**
11040
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 20 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) 304 North Reader	

3. NAME OF DECEASED (Type or Print) a. (First) Albert b. (Middle) Cyrus c. (Last) Toler			4. DATE OF DEATH (Month) (Day) (Year) 12 25 50		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 30, 1877	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	11. BIRTHPLACE (State or foreign country) Goreville, Illinois	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Larkin Toler	13b. MOTHER'S MAIDEN NAME Mary Goddard	14. NAME OF HUSBAND OR WIFE Valley Frances Toler
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Albert Toler Jr.	ADDRESS 415a Columbia Pl.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CADUPTIC STROKE		INTERVAL BETWEEN ONSET AND DEATH 6 mos.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 12-15-50	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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? 151X

22. I hereby certify that I attended the deceased from **12-5**, 19**50**, to **12-25**, 19**50**, that I last saw the deceased alive on **12-25**, 19**50**, and that death occurred at **6:10 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert H. Hoppe M.D. (Degree or title)	23b. ADDRESS Barnes Hospital Mo	23c. DATE SIGNED 12/25/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12-26-50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Mounds, Illinois
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DATE REC'D BY LOCAL REG. DEC 26 1950	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed J. Wm Binsley

Signed.....
Student Embalmer

Licensed Embalmer No. 3657

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.