

FILED AUG 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22189**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 823

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>	
c. LENGTH OF STAY (in this place) <u>1 day</u>		d. STREET ADDRESS (If rural, give location) <u>3119 Gene Field Road</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp.</u>			
3. NAME OF DECEASED a. (First) <u>Jennie</u> b. (Middle) _____ c. (Last) <u>Tolin</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 26, 1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>April 30, 1873</u>
9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. practical nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Joseph, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Tolin</u>		13b. MOTHER'S MAIDEN NAME <u>Kate Turner</u>	
14. NAME OF HUSBAND OR WIFE _____		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>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Katherine Bayless</u> ADDRESS <u>3119 Gene Field Rd St Joseph, 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>Acute Respiratory Failure</u>			DUE TO (b) <u>Hydrothorax</u>			<u>15 min.</u>		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			DUE TO (c) <u>Myocardial Failure</u>			<u>6 hours</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>Diabetes mellitus</u>			<u>1 mo.</u>		
19a. DATE OF OPERATION _____			19b. MAJOR FINDINGS OF OPERATION <u>Fracture - Intertrochanteric Rt. hip</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____	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 June 20, 1951, to July 26, 1951, that I last saw the deceased alive on 7/25, 1951, and that death occurred at 10:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>G. T. Bloomer, M.D.</u> (Degree or title) <u>0</u>	23b. ADDRESS <u>1218 N. 32nd St. St. Joseph, Mo</u>	23c. DATE SIGNED <u>7/30/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>7/28/1951</u>	24c. NAME OF CEMETERY OR CREMATORIUM <u>Mt. Mora</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Aug 7, 1951</u>	REGISTRAR'S SIGNATURE <u>Case C. Calhoun</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Heater-Buonan Funeral Home</u> ADDRESS <u>St Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. G. Edmonston

Licensed Embalmer No. 4791

P. O. Address 319 So 10 St. Joseph

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.