

pt. Health,  
, & Welfare  
S. Public  
th Service

FILED DEC 5 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40640  
STATE FILE NUMBER  
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5428

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>636 E. 61st Terrace 1 yr</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>636 E. 61st Terrace</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>LOUIS CLEMENT TOBIN</b>			4. DATE OF DEATH Month Day Year <b>November 16 1957</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1892</b>	9. AGE (In years birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Superintendent</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Swift &amp; Co.</b>	11. BIRTHPLACE (City and state or country) <b>Brunswick, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Theodore Tobin</b>	13b. MOTHER'S MARRIAGE AND DIVORCE <b>Elpasa, divorced</b>	13c. MOTHER'S MARRIAGE AND DIVORCE <b>Katherine Strub</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>443-01-8953</b>	17. INFORMANT Address <b>Miss Isabelle Tobin, 636 E. 61st Terrace</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>H. L. Dwyer M.D.</b>	22b. ADDRESS <b>City Hall Brunswick Mo</b>	22c. DATE SIGNED <b>11-16-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial &amp;</b>	23b. DATE <b>11-18-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Boniface Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Brunswick, Mo.</b>
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24. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar Funeral Home</b>	ADDRESS <b>1800 E. Linwood, K. C., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-16-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>
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1800 E. Linwood, K. C., Mo. (Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

H. L. Dwyer



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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *James W. Wair* \_\_\_\_\_

Licensed Embalmer No. *4650*

P. O. Address *K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.