

FILED MAR 17 1958

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-008987

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 241

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan <i>0/17</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in lb life	d. STREET ADDRESS (If outside, give location) 2816 Angelique		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EMERY Middle LUTHER Last TILSON			4. DATE OF DEATH Month March Day 4 Year 1958		
5. SEX male <i>0</i>	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1894	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Quaker Oats Co.	11. BIRTHPLACE (City and state or country) St. Joseph, Mo. <i>0</i>		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Leslie Tilson		13b. MOTHER'S MAIDEN NAME Olie Bartholomew		14. NAME OF HUSBAND OR WIFE Nonie	
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. 491-10-0176	17. INFORMANT Address St. Joseph, Mo. Emery L. Tilson, Jr. 6423 Carnegie		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism Acute Respiratory Inefficiency of Subtotal Gastric Stomy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) Duodenal ulcer with hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 6 hrs 48 hrs 4 days 12 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5410					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
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	
21. I attended the deceased from Sept 2, 1953 to March 4, 1958 and last saw ^{her} him alive on March 4, 1958 Death occurred at 7:30p. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE S. P. Lenox M.D. (Degree or title) <i>0</i>			22b. ADDRESS St. Joseph Mo		22c. DATE SIGNED 3-6-58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/7/1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
24. FUNERAL DIRECTOR Heaton-Bowman Funeral Home		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Mar 11, 1958		26. REGISTRAR'S SIGNATURE Mrs. Clark Hodell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUN 7 6 1959

MAY 28 1959

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 *William Spallans*

Licensed Embalmer No. *29535*

P. O. Address *319 S. 10th Ave*

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.