

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005274
STATE FILE NUMBER

FILED MAR 2 1959

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 31

300
-57

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY Grundy	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Trenton		c. CITY OR TOWN Trenton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home 1307 Cedar		d. STREET ADDRESS (If outside, give location) 1307 Cedar st.	
3. NAME OF DECEASED (Type or print) First Middle Last Melvin John Tollefson		4. DATE OF DEATH Month Day Year Feb. 21, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Engineer Trenton Foods		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) South Dakota
13a. FATHER'S NAME John Tollefson		13b. MOTHER'S MAIDEN NAME Sarah S. Keldurn	14. NAME OF HUSBAND OR WIFE Lucille
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address Lucille Tollefson Trenton, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 30 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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 type="checkbox"/> c.
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.) 4201	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) M. G. Gipson		22b. ADDRESS Trenton Mo	22c. DATE SIGNED Feb 23 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/26/59	23c. NAME OF EMBALMER OR CREMATORY Forrest Hills	23d. LOCATION (City, town, or country) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR M. G. Gipson		25. DATE RECD. BY LOCAL REG. 2-25-59	26. REGISTRAR'S SIGNATURE Gene Fair

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 26 1959
MAR 17 1959

APR 9 1959

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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: *[Handwritten Signature]*

Licensed Embalmer No. *4959*
P. O. Address: *[Handwritten 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.