

Dept. Health,  
 Soc. & Welfare  
 J. S. Public Health Service

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

-60-039054  
 STATE FILE NUMBER

FILED VS NOV 2 1960

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 69

V. S. 300  
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Charleston, Mo.</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>50 308 N. Elm St.</b>		Length of stay in lb <b>1 Year</b>	d. STREET ADDRESS (If outside, give location) <b>0672 308 N. Elm</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jim Frank Tollison</b>			4. DATE OF DEATH Month Day Year <b>Oct. 21 1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-1884</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>76</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR OCCUPATION <b>Wickens Co.</b>		11. BIRTHPLACE (City and state or country) <b>Plummerville, Ark.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Willie Tollison</b>		13b. MOTHER'S MAIDEN NAME <b>Polly Broadway</b>	
14. NAME OF HUSBAND OR WIFE <b>Jane Tollison</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Jane Tollison</b>		Address <b>Charleston, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>4201</u>					
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? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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 <u>Oct 21, 1960</u> , to <u>Oct 21</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Oct 21, 1960</u> Death occurred at <u>8:45 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>Charleston Mo</u>		22c. DATE SIGNED <u>10-25-60</u>
23a. BURIAL, CREMATION, REPOSING (Specify) <b>Burial</b>		23b. DATE <b>10-23-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Armour</b>		23d. LOCATION (City, town, or county) (State) <b>Mississippi County, Mo.</b>
24. FUNERAL DIRECTOR <b>Shelby Funeral Home E. P. Mo.</b>		ADDRESS <b>East Prairie, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>10-28-60</b>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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

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 *Thomas Shelby Jr.* .....

Licensed Embalmer No. *4940* .....

P. O. Address *East Prarie* .....

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.