

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

[REDACTED]
 STATE OF MISSOURI
 1201-163-032004

Registration District No. 122 Primary Registration District No. 2000 Registrar's No. 1201-163-032004

FILED AUG 26 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission)	
a. COUNTY Greene		a. STATE Mo.	b. COUNTY Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Mt. Vernon	
Length of stay in lb 6 wks.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) 707 So. Main	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Hocker Tolliver			4. DATE OF DEATH Month Day Year August 11 1963
5. SEX Female	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 12/15/1881
9. AGE (last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mt. Vernon, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Charles Hocker	
13b. MOTHER'S MAIDEN NAME Theresa Bell		14. NAME OF HUSBAND OR WIFE Henry Tolliver, dec'd.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) no		17. INFORMANT Address Mrs. Andye Hocker, Picher, OH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia from metastatic adenocarcinoma of Colon Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 16 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition listed in PART I (a) Generalized arteriosclerosis			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 1944 to 8/11/63 and last saw her alive on 7/29/63 Death occurred at 5:00 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Benneth Glover MD		22a. ADDRESS Mt. Vernon, Mo.	
22b. DATE SIGNED 8/13/63		22c. ADDRESS Mt. Vernon, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 8/13/63	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City, town, or county) Mt. Vernon, Mo.
24. FUNERAL DIRECTOR Max L. Fossett		25. DATE RECD. BY LOCAL REG. 8-14-63	26. REGISTRAR'S SIGNATURE Bennie Medley
ADDRESS Mt. Vernon, Mo.			

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

10397

205502

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

OCT 29 1963

SEP 19 1963

8/11/63

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 Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address M. Vernon, Va.

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.