

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County Randolph Registration District No. 729 File No. 28638<sup>a</sup>  
 Township Leino Primary Registration District No. 5963 Registered No. 7  
 City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Julithen M. Tomlinson

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. ~~SINGLE~~ MARRIED ~~WIDOWED~~ OR DIVORCED (write the word) no

5A. ~~IF~~ MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Tomlinson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/21/1845

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
84 | 2 | 24

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co Mo

10. NAME OF FATHER Ezekiel Vincent

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Virgil Tomlinson (Address) Madison Mo

15. Sept 10 1929 Dr J.P. Allen REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 8/15 1929

17. I HEREBY CERTIFY That I attended deceased from 8/12, 1929, to 8/15, 1929, and that I last saw him alive on 8/15, 1929, and that death occurred, on the date stated above, at 9 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

930C Cor. Ar. Closure  
930D Ch. Myocarditis

CONTRIBUTORY Senile debility (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED at home (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

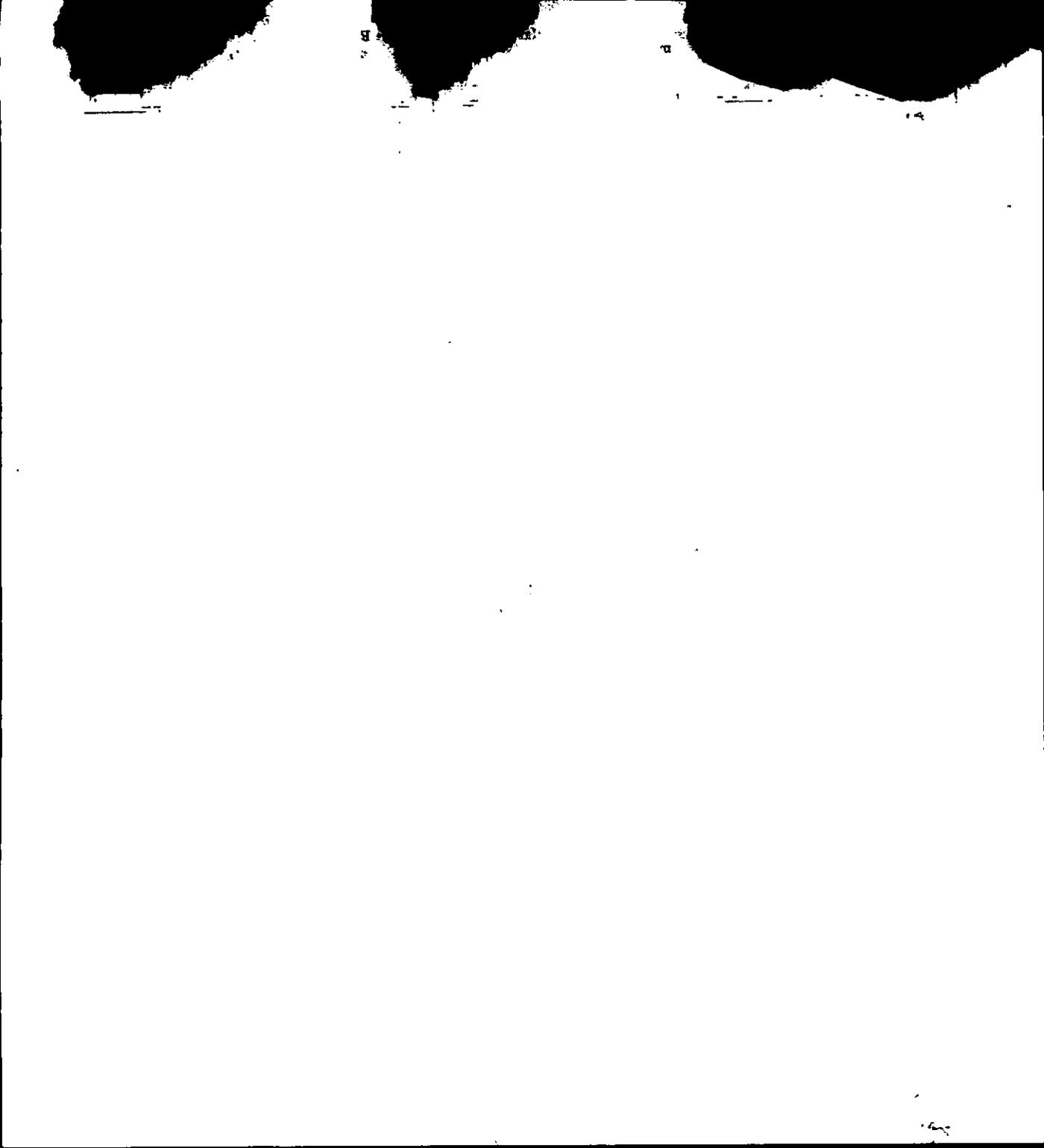
WHAT TEST CONFIRMED DIAGNOSIS? H.C. Griffiths, M.D.  
 (Signed) \_\_\_\_\_, 19 \_\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Beckony Grove DATE OF BURIAL 8/16 1929

20. UNDERTAKER Fred W. Thompson ADDRESS Madison Mo

EXACTLY. If information of OCCUPATION is not carefully supplied, it may be properly classified as \_\_\_\_\_



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Randolph  
Township Cairo  
City (No. .... St. .... Ward)

Registration District No. 729  
Primary Registration District No. 5963

File No. ....  
Registered No. 7

**2. FULL NAME**

Sabithia M Tomlinson

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER Ezekiel  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
12. MAIDEN NAME OF MOTHER Unknown  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address)

15. Sept 10, 19 29 S. J. P. Allen REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 15 19 29

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

PERMANENT PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIAN is very important. Exact state of OCCUPATION. COMPLETE AS PRESCRIBED. FEE FOR CERTIFICATES UNIT. N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH.

SUPPLEMENTARY

S-28638-A