

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32757
Do not use this space.

REC'D OCT 12 1939

1. PLACE OF DEATH

(a) County Johnson Registration District No. 437
 (b) Township Free Hill Primary Registration District No. 5594 Registered No. _____
 (c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. 940 How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Infant Son of E.D. & Mae Toble
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 3 - 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, 9 hrs. or min.
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 3, 1939

22. I HEREBY CERTIFY That I attended deceased from at Delivery, Oct 3, 1939, 19____

I last saw h. in alive on Oct 3, 1939. Death is said to have occurred on the date stated above, at 7:00 P.M.

The principal cause of death and related causes of importance were as follows:

Premature Birth (7 months)
Hard Lip - Cleft Palate
Spina Bifida
Congenital deformity of leg.
 Date of onset _____

Other contributory causes of importance:
15' h

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify: _____
 (Signed) Kelly Rawlin, M. D.
 (Address) Holden Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER
 13. NAME Edward D. Toble
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
 15. MAIDEN NAME Mae Dove

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) E. D. Toble Holden Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Filbert Cemetery DATE Oct 4, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) T. M. Goodman Holden Mo

20. FILED Oct 4, 1939 Anna Colman Local Registrar

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. NO. 2.
 50M-9-19-38
 I X16905

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10/9/39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. 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 this body is not embalmed, above space should be left blank.