

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
1 x 11

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6677

State File No.

205

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
 (c) Name of hospital or institution: Burge Hospital 1
 (d) Length of stay: in hospital or institution
 In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Springfield
 (d) Street No. 308 S. National
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Jesse A. Tolerton 45

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Pearl S. Tolerton 6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased July 23 1874
 (Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days 6 If less than one day hr. min.

9. Birthplace Salina Ohio
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Banker

11. Industry or business In Bank

12. Name Jesse A. Tolerton
 13. Birthplace Salina 9
 (City, town, or county) (State or foreign country)

14. Maiden name Salina
 15. Birthplace Salina 9
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Pearl S. Tolerton
 (b) Address 308 S. National Ave

17. (a) Burial (b) Date thereof 2-2-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marys Park

18. (a) Signature of funeral director Allyn Schmeyer
 (b) Address Springfield, Mo

19. (a) 2/2/46 (b) Chas. A. George
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29th year 1940 hour 2: minute 30 A. M.

21. I hereby certify that I attended the deceased from June 1, 1946, to 2/29, 1946; that I last saw him alive on 2/22, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Purkinje mean Syndrome with terminal pneumonia Duration 4 days

Due to Influenza & following encephalitis (the encephalitis was never recognized)

Other conditions had some manifest type cometa
 Major findings: type pneumonia with

Of autopsy terminal pneumonia brain not yet examined

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature F. J. Tolerton (M. D. counter) 1
 Address Springfield Mo Date signed 2/2/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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MAY 18 1948

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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 Charles George Registered Apprentice No. 204
working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 1767
P. O. Address [Signature]

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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6677
Registrar's No. 205-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 318

Primary Registration District No. 2001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Jose A. Tolleston
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year) _____

8. AGE: Years Months Days If less than one day
65 7 6 hr. min.

9. Birthplace (City, town, or county) (State or foreign country) _____

10. Usual occupation _____

MOTHER FATHER { 11. Industry or business _____
12. Name _____
13. Birthplace (City, town, or county) (State or foreign country) _____
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

20. DATE OF DEATH: Month 2 day 29 year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Parkinsonian Syndrome with terminal Pneumonia
Due to _____
Influenza following Enceph
Due to _____
alitis
The encephalitis was _____
Other conditions _____
Major findings: _____
Of operations: _____
Of autopsy: _____
Diagnosis: Parkinsonian

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature F. H. Douglas (M.D. or other) M.D.
Address Springfield made signed

SUPPLEMENTARY

