

FILED AUG 16 1940

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

28302

Do not use this space.

1. PLACE OF DEATH

(a) County..... **CLINTON** Registration District No. **206**
 (b) Township..... Primary Registration District No. **W127**
 (c) City..... **TURNEY** (d) Street No. _____ St.
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

FRANCIS WAYLAND TILLET
 (a) Residence, No. **TURNEY** 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) **WIDOWED**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE **BROOKSIE CHASE**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **APRIL 2, 1872**
 7. AGE YEARS **68** MONTHS **4** DAYS **2** If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **FARMER**
 9. Industry or business in which work was done, as saw mill, bank, etc. **FARM**
 10. Date deceased last worked at this occupation (month and year) **Aug. 1940** 11. Total time (years) spent in this occupation **58**
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **DANDRIDGE TENNESSEE**
 FATHER 13. NAME **JOHN TILLET**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **DANDRIDGE TENNESSEE**
 MOTHER 15. MAIDEN NAME **MARIA CROUCH**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **FALL BRANCH TENNESSEE**
 17. INFORMANT **ENID WALKER** (ADDRESS) **TURNEY, MO.**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **BURIAL LATHROP Mo.** DATE **Aug. 5, 1940**
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **De Moss CORANK LATHROP, MO.**
 20. FILED **Aug 6, 1940** **E. B. Dunham** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Aug. 4, 1940**
 22. I HEREBY CERTIFY, That I attended deceased from **Aug. 3, 1940** to **Aug. 4, 1940**
 I last saw him alive on **Aug. 4, 1940** Death is said to have occurred on the date stated above, at **1.15A.**
 The principal cause of death and related causes of importance were as follows:
Myocardial Failure Date of onset **Aug. 3.**
 Other contributory causes of importance:
Coronary Sclerosis / Acute Food Poisoning ? **Aug. 3.**
 Name of operation **None** Date of _____
 What test confirmed diagnosis? **Examination** 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) **Henry W. Perry** M.D.
 (Address) **Lathrop Mo.**

RECEIVED

District Health Officer No. 11,

District File Number 940-1412

Date Filed SEP 12 1940

177
99

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.....

working under my personal supervision.

See Mrs. Burk

Registered Apprentice No.

Signed.....

See Mrs. Burk

Licensed Embalmer No. 2533

P. O. Address Latting, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28302**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **206**

Primary Registration District No. **4127**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Clinton**
(b) City or town **Journey**
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether _____)
In this community _____ years, months or days

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.

3. (a) PRINTED FULL NAME **Francis Wayland Tillet**

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 **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years **68** Months **4** Days **2** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **Aug** day **4** year **1970** 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 **myocardial infarction** Duration _____

Due to _____ 1977

Due to _____ 4th

Other conditions **Coronary sclerosis**
(Include any within 3 months of death)
acute food poisoning

Major findings: Of operations _____

Of autopsy **over**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 **Henry M. Perry** (M. D. or other)

Address **Fathrap** in _____ date signed _____

SUPPLEMENTAL

If possible please state the food
causing acute food poisoning.

*Overripe bananas - that had
been thrown away by local
grocer - according to information
given me.*

Please write requested information
on face of supplemental and return
in the enclosed franked envelope.

Thank you

Harry F. Parker, M.D.

Harry F. Parker, M.D.
Special Agent, Bureau of the Census