

FILED NOV 7 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34586

Registration District No. 147

Primary Registration District No. 4081

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Archie Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 7047 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass 19  
(c) City or town Archie 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29  
year 1941 hour 9 o'clock minute 10 - A.M.

21. I hereby certify that I attended the deceased from Apr. 29 1937 to Oct. 27 1941;  
that I last saw him alive on Oct. 27 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Paralysis Agitans

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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) Means of injury 0

23. Signature J. S. Triplett M.D. (M. D. or other)  
Address Harrisonville, Mo. Date signed 10-27-41

8. (a) PRENT FULL NAME Benjamin Baker Tout

3. (b) If veteran, name war \_\_\_\_\_ (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 Annie Tout 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased: Apr. (Month) 5 (Day) 1867 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>6</u>	<u>24</u>	_____ hr. _____ min.

9. Birthplace Hendricks County Ind. 1 (City, town, or county) (State or foreign country)

10. Usual occupation Medical Doctor

11. Industry or business doctor

12. Name William Harrison Tout

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

14. Maiden name Lucinda Ruggles

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

16. (a) Informant Mrs. Annie Tout

(b) Address Archie, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill

18. (a) Signature of funeral director Atkinson Bros.

(b) Address Archie, Mo.

19. (a) 10-21-41 (Date received local registrar) (b) Mrs. Dora Bell (Registrar's signature)

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

*Hoyd Atkinson*

Licensed Embalmer No.

*3920*

P. O. Address

*Harrisonville*

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.