

FILED JAN 21 1948
Registration District No. **317**

Primary Registration District No. **6676**

1. PLACE OF DEATH:

(a) County **ST LOUIS**
(b) City or town **JENNINGS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Edna Nursing Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 mo**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **ST LOUIS**
(c) City or town **Overland**
(If outside city or town limits, write "RURAL")
(d) Street No. **Woodson & Baltimore Ave**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Jefferson Tonkins**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct 16, 1959**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	89	2	29	hr. _____ min.

9. Birthplace **St Louis Co. Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business:

12. Name **HENRY TONKINS**
13. Birthplace **St Louis Co. Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **ST LOUIS Mo. O**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS VIRGIE CAMPTON**
(b) Address **9065 Woodland Overland**

17. (a) **Burial** (b) Date thereof **JAN 16, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Fee Fee Cem**

18. (a) Signature of funeral director **BAUMANN Brothers**
(b) Address **2004 Woodson Rd Overland Mo**

19. (a) **1-15-48** (b) **George Johnson MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **14**
year **1948** hour **3** minute **00** P.M.
21. I hereby certify that I attended the deceased from **December 14, 1947** to **January 14, 1948**
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Duration
Immediate cause of death **Cerebral thrombosis** **2 days**
Due to **arteriosclerotic Cardiovascular renal disease** **3 yrs**

Other conditions **Old fracture pelvis** **2 mos**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy **1948**
Underline the cause of 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 **1/6**
(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? _____ (Specify type of place)
While at work? _____ (e) Means of injury **0**
Signature **Lewis Littmann** (M. D. or other) **M.D.**
Address **8231 Clayton Rd** Date signed **1/15/48**

MOTHER FATHER

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 345

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

Signature David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7-123
Registrar's No. 123

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Jefferson
(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)

3. (a) PRINT FULL NAME Jefferson Tarbinis
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

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

7. Birth date of deceased Oct 16 (Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 10 (less than one day) _____ min.

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

10. Usual occupation _____

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M. 15
21. I hereby certify that I attended the deceased from Dec 15 to Jan 14, 1948
that I last saw him alive on Jan 8, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: General thrombosis Duration 1 day
Due to Arterio-sclerotic cardiac
vascular disease

Other conditions: Fracture of pelvis 2 mos
(Include pregnancy within 3 months of death)

Major findings: 166X
Of operations _____ 18.4
Of autopsy _____

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

22. If death was due to external causes, fill in the following: remote cause
Accidental fall

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence Jan 6, 1948

(c) Where did injury occur? Jefferson St Louis Co Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Nursing Home (public place)

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

1948
S-3591