

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016477

STATE FILE NUMBER

FILED APR 23 1959

Registration District No. 347

Primary Registration District No. Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Stone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rutledge</u>		c. CITY OR TOWN <u>Rutledge</u> 1040	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMMY COLLEN TOLBERT</u>		4. DATE OF DEATH Month Day Year <u>Apr 8 - 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 7 1959</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Rutledge Stone Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Lloyd Earl Tolbert</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Begno Pendergrass</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Name Address <u>L. E. Tolbert Galena Mo R 3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature death. (8 1/2 mo)</u> DUE TO (b) <u>Death known cause</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>776X</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Apr 7 1959</u> to <u>Apr 8 1959</u> and last saw her alive on <u>Apr 8 1959</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>L. S. Shumate M.D.</u> (Degree or title)		22b. ADDRESS <u>Beeds Springs Mo</u>	
22c. DATE SIGNED <u>Apr 8 1959</u>		22d. LOCATION (City, town, or county) (State) <u>Beeds Springs Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>April 9 - 1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Galena Pond</u>		23d. LOCATION (City, town, or county) (State) <u>Beeds Springs Mo</u>	
24. FUNERAL DIRECTOR <u>Family</u>		25. DATE RECD. BY LOCAL REG. <u>April 9 - 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. J. Colan Brouseau per J. M. Murray</u>			

MEDICAL CERTIFICATION

DO NOT WRITE IN THIS BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, Student Embalmer No.
working under my personal supervision.

Student Signed *Eurett J. Cheatham*
Signature of Student Embalmer

Licensed Embalmer No. *3870*
P. O. Address *Halena*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.