

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

DEC 29 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Washington Registration District No. 881 File No. 42763
Township Identy Primary Registration District No. 6181 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Delozah Sullivan

(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Husband Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 1 1871</u>		
7. AGE YEARS <u>66</u>	MONTHS <u>8</u>	DAYS If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Pent Loushy Mo</u>		
FATHER 13. NAME <u>Delozah Sullivan</u>	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>	
MOTHER 15. MAIDEN NAME <u>Mary Shepard</u>	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
17. INFORMANT (ADDRESS) <u>Gray Sullivan</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Potosi Mo</u> DATE <u>Dec 3 1937</u>		
19. UNDERTAKER (ADDRESS) <u>Shepard</u>		
20. FILED <u>Dec 10 1937</u> <u>G. P. Resmille</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 27 1937

22. I HEREBY CERTIFY, That I attended deceased from No Physician, 19____, to____, 19____
I last saw h. _____ alive on never, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Freezing, due to exposure and alcoholic intoxication.
Date of onset _____

Other contributory causes of importance:
Coronary infarct.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? 40

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) Joseph L. Florman Coroner, M. D.
(Address) Potosi, Mo.

1974-12-25

Department of Health, Education and Welfare

Office of the Assistant Secretary for Health

Washington, D.C. 20462

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FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

42763
Do not use this space.

1. PLACE OF DEATH

(a) County Washington Registration District No. 887
 (b) Township Liberty Primary Registration District No. 6181 Registered No. _____
 (c) City _____ (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 Elizab Sullivan

(a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 27 1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h..... alive on _____, 19..... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 66 10 26

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired farmer
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER 13. NAME

Name of operation _____ Date of _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury _____

Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____, 19____

24. Was disease or injury in any way related to occupation of deceased? _____

19. FUNERAL DIRECTOR (ADDRESS)

If so, specify _____ (Signed) Joseph L. Thurman M.D.

20. FILED Jan 27 1938 G.T. Casner Local Registrar.

(Address) Paterson you

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. PHYSICIANS SHOULD STATE OCCUPATION IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. AGE SHOULD BE STATED EXACTLY.

SUPPLEMENTARY

