

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.

RECD JUL 6 1939

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

22051
Do not use this space.

1. PLACE OF DEATH

(a) County FRANKLIN Registration District No. 295
 (b) Township Meramec Primary Registration District No. 4179
 (c) City Sullivan (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 20 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 360 ANNIE DOTY SULLIVAN, MISSOURI St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED
 5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF LOT E. DOTY.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 2, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
62. 8 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) May 31, 1939 11. Total time (years) spent in this occupation 69

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Clair Missouri.

FATHER 13. NAME Thomas E. Judd
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio.

MOTHER 15. MAIDEN NAME Martha Deaton
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) S. Carolina

17. INFORMANT (ADDRESS) Sarah E. Caldwell Sullivan, Missouri.

18. BURIAL, CREMATION, OR REMOVAL PLACE Cave Springs DATE June 13, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thos. P. Shaffer Sullivan, Missouri.

20. FILED 6/12 1939 Clatsop Local Registrar. 733

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from May, 1935 to June 12, 1939
 I last saw her alive on June 11, 1939; Death is said to have occurred on the date stated above, at 1:35 AM.
 The principal cause of death and related causes of importance were as follows:

MYOCARDITIS

Date of onset ?

Other contributory causes of importance: _____

Name of operation NONE Date of _____
 What test confirmed diagnosis? CLIN. 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) R. C. Mitchell, M. D.
Sullivan, Missouri (Address)

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

Edgar W. Laffan

Licensed Embalmer No. *3344*

P. O. Address *Sullivan, N.Y.*

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.