

1. PLACE OF DEATH:
 (a) County Jefferson
 (b) City or town DeSoto
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Not in hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
(Specify whether)
 In this community 5 Months
years, months or days

3. (a) PRINT FULL NAME Howard Allen Sullivan
3. (b) If veteran, name war Infant **3. (c) Social Security No.** _____

4. Sex Male **5. Color or race** White **6. (a) Single, widowed, married, divorced** Infant
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased March 17, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 5 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business Stoney A. Sullivan

12. Name Stoney A. Sullivan
18. Birthplace LaBelle (City, town, or county) Mo. (State or foreign country)

14. Maiden name Bernina Hayeten
15. Birthplace Jefferson City (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Stoney A. Sullivan
(b) Address DeSoto Mo.

17. (a) Buried (Burial, cremation, or removal) Buried **(b) Date thereof** Sept 8, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation DeSoto Mo.

18. (a) Signature of funeral director Lee Mothershead
(b) Address DeSoto Mo.

19. (a) 10-8-40 (Date received local registrar) **(b) Geneva Darnell** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jefferson
 (c) City or town DeSoto
(If outside city or town limits write "RURAL")
 (d) Street No. Kenneth St
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 7
 year 1940 hour 1 minute _____ P.M.

21. I hereby certify that I attended the deceased from Sept 3rd, 1940, to Sept 7, 1940, that I last saw him alive on _____ 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Gastro enteritis **Duration** 10 days

Due to _____
 Due to Rickets 114 Pa

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to 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 _____

(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? 301
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature J. P. Longels (M. D. or other) 3
Address DeSoto Mo. **Date signed** 9-9-40

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

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

W. B. Noehushead

Licensed Embalmer No. 3531

P. O. Address Polom

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.