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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38623

State File No. _____

Registration District No. 289

Primary Registration District No. 5407

Registrar's No. 6059

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Malden, Route 2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Putnam Hall
(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 SARAH JANE Gulleage
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex female 5. Color or race wh
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Charles B. Gulleage
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 10 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 17
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name D.K.
13. Birthplace D.K.
(City, town, or county) (State or foreign country)
14. Maiden name Betsie Johnson
15. Birthplace Pennesse
(City, town, or county) (State or foreign country)

16. (a) Informant P. A. Stolla
(b) Address Malden, Mo, Route 2
17. (a) burial (b) Date thereof 11 28 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Stephens Cemetery

18. (a) Signature of funeral director _____
(b) Address Malden, Mo
19. (a) 11-27-40 (b) S.E. Mitchell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Malden, Mo, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27
year 1940 hour 4 minute a M.
21. I hereby certify that I attended the deceased from _____
im attended by a Physician
and that death occurred on the date and hour stated above.
that I last saw h _____ alive on _____, 19 _____

Immediate cause of death Cerebral Thrombosis Feb 27
Due to Arteriosclerosis 10 years

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

Major findings:
Of operations _____
Of autopsy _____

Duration
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?
2 10 40
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature George Gulleage (M.D. or other) DD
brother of Deceased
Address _____ Date signed 11 27

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

RECEIVED

District Health Officer No. 2

District File Number 240-180

Date Filed 12/11/49

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.....

Licensed Embalmer No.....

P. O. Address.....

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.