

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1942

Registration District No. 725

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5960C

State File No. 25086

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Center, R F D
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether
In this community Life years, months or days)

3. (a) PRINT FULL NAME Margarte Sulgrove

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charley Sulgrove 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Feb 14 1872
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 28 If less than one day
hr. min.

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

10. Usual occupation House wife

11. Industry or business Own Home

12. Name Thomas Evans

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

14. Maiden name Catherine Butler

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

16. (a) Informant's own signature Charley Sulgrove

(b) Address Center Mo

17. (a) Burial (b) Date thereof July 14 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vandalia, Mo.

18. (a) Signature of funeral director Miss Earl Perkins

(b) Address Center Mo

19. (a) July 13-42 (b) Miss Earl Perkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls
(c) City or town Center R F D
(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? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1942 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 13
1942 to July 12 1942
that I last saw her alive on June 12
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Nephritis
Due to unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

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

23. Signature C. H. Burke (M. D. or other) Dr.
Address Center, Mo. Date signed 7/13/42

RECEIVED

District Health Officer No. 10

District File Number 8-42-1345

Date Filed AUG 11 1942

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. 3356

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25086**

Registration District No. **725**

Primary Registration District No. **5960C**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Ralls**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 **Margaret Sulgrove**
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife **Charles** 6. (c) Age of husband or wife if alive **14** years
7. Birth date of deceased **Feb 14 1922**
(Month) (Day) (Year)

8. AGE: **69** Years **4** Months **28** Days **no** min.
(If less than one day)

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** year **1942** hour **12** minute **00** M.
21. I hereby certify that I attended the deceased from **1942** to **1942**,
that I last saw him **live** on **July 14**, 19**42**,
and that death occurred on the date and hour stated above.
Immediate cause of death **myocarditis**
(acute)
Due to **nephritis acute 2mo.**
Due to **unknown probably Chronic Nephritis**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **131**
Of autopsy

Duration **1mo**

PHYSICIAN

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?

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

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

