

Registration District No. 363

Primary Registration District No. 6196

Registrar's No. ....

1. PLACE OF DEATH

(a) County Texas  
 (b) City or town Licking  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Sherrill Hosp  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County 107  
 (c) City or town..... 50  
(If outside city or town limits, write "RURAL.")  
 (d) Street No..... 0  
(If rural, give location)  
 (e) Citizen of foreign country?..... 0  
(Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME Rachel Ellen Sullins

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 Widowed  
 6. (b) Name of husband or wife C. Sullins 6. (c) Age of husband or wife if alive 30 years  
 7. Birth date of deceased Mar 20 1867  
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 18 If less than one day  
hr. min.

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

10. Usual occupation House work

11. Industry or business David Mitchell

12. Name Not know

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

14. Maiden name Elizabeth Wheeler

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

16. (a) Informant Ma Jenkins

(b) Address.....

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

(c) Place: burial or cremation Graddock Cen.

18. (a) Signature of funeral director Smith Ferguson

(b) Address Licking MO

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 P  
 year 1942 hour..... minute 30 M.

21. I hereby certify that I attended the deceased from June 6 1942 to June 8 1942  
 that I last saw him alive on June 8 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis  
 Due to Bad kidney

Due to.....  
 Other conditions (include pregnancy within 3 months of death) 92

Major findings: Of operations.....  
 Of autopsy.....  
 PHYSICIAN 92  
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?

While at work?.....  
(Specify type of place) (e) Means of injury  
 23. Signature Lulu Randall (M. D. or other).....  
 Address Licking MO Date signed.....

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

27  
00  
0

1237

**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 ML

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Robert E. Ferguson

Licensed Embalmer No.

3945

P. O. Address

Licking MO

**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.**

S. No. 1-934 141  
5-17-11  
A X27288

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25-552

Registration District No. 353

Primary Registration District No. 6196

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Licking, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Rachel Ellersullina

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

4. Sex F 5. Color w race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 25  
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days no if less than one day \_\_\_\_\_ min.

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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I personally saw him/her die on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

(Immediate cause of death) \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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)

(b) 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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

