

No. 2
1-4-41
17-39
X24390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

2294

Registration District No. 128

Primary Registration District No. 2000

State File No. _____

Registrar's No. 19

39
6

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

1. PLACE OF DEATH: GREENE

(a) County..... Greene

(b) City or town..... Springfield, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Bantist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community..... Child (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town..... Springfield, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1740 W. Walnut
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Patsy Janette Sullinger

3. (b) If veteran, name war..... Child None 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
year 1943 hour 7 minute A.M.

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife..... None 6. (c) Age of husband or wife if alive X X years

7. Birth date of deceased Jan. 7 1943
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-8-43, 19, to 1-8-43, 19, that I last saw her alive on 1-8, 19, and that death occurred on the date and hour stated above.

8. AGE: Years 0 Months 0 Days 1 If less than one day hr. min.

Immediate cause of death Prematurity

Due to Premature 7 1/2 mo. gestation

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

Due to.....

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

10. Usual occupation Child

Major findings:
Of operations.....

11. Industry or business Child

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER 12. Name W. H. Sullinger

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

14. Maiden name Ide L. Wallis

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

16. (a) Informant W. H. Sullinger

(b) Address 1740 W. Walnut Springfield

17. (a) Burial (b) Date thereof 1-8-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenl: wn

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address Springfield, Mo.

19. (a) 1-8-43 (b) S. W. Handley
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other)

Address Springfield, Mo. Date signed.....

984

(Licensed Embalmer's Statement on Reverse Side)

XI

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.....

Body not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed *Frank Grable Jr.*

Licensed Embalmer No. *4140*

P. O. Address *Springfield, Ind*

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.