

11281

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 7 1943

Registration District No. 314

Primary Registration District No. 4459

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Osceola
(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
In this community over 37 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Clair
(c) City or town Osceola (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

3. (a) PRINT FULL NAME E. Watson Sullivan M. D.

3. (b) If veteran, name war World War #1 3. (c) Social Security No.

4. Sex male 5. Color or Race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nellie SeEVERS-Sullivan 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Feb 23 1943
(Month) July (Day) 14-1872

8. AGE: Years 70 Months 7 Days 14 If less than one day hr. min.

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

10. Usual occupation physician M. D.

11. Industry or business

12. Name Jerome Parker Sullivan
13. Birthplace Dover Mason Co. Kentucky (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Frances Jefford
15. Birthplace Marion Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Nellie Sullivan
(b) Address Osceola Mo.

17. (a) 3/2/1943 (b) Date thereof Osceola, Mo
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Mo

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

(b) Address Osceola Mo

19. (a) 3-2-1943 (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28 1943
year hour 8 P.M. minute M.

21. I hereby certify that I attended the deceased from 1941
to 2/28 1943
that I last saw him alive on 2/28/1943
and that death occurred on the date and hour stated above.

Immediate cause of death malignancy of rectum and abdomen

Due to old trauma 1918

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy none

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)
(c) Means of injury
23. Signature Ruth SeEVERS (M. D. or other)
Address Osceola Mo Date signed 3/2/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3

F-41
7-39
X29484

1160

(Licensed Embalmer's Statement on Reverse Side)

APR 26 1943

RECEIVED

District Health Officer No. 7,

District File Number

3-43-50

Date Filed

4-6-43

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

J. B. Goodrich

Licensed Embalmer No.

3038

P. O. Address

Osselle 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11281

Registration District No. 314

Primary Registration District No. 440-9

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Osceola
(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)

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 _____

3. (a) PRINT FULL NAME E. Watson Sullivan M.D.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him/her live on _____, 19____; and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased: July 14 (Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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) [Signature]
(Date received local registrar) (Registrar's signature)

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 _____

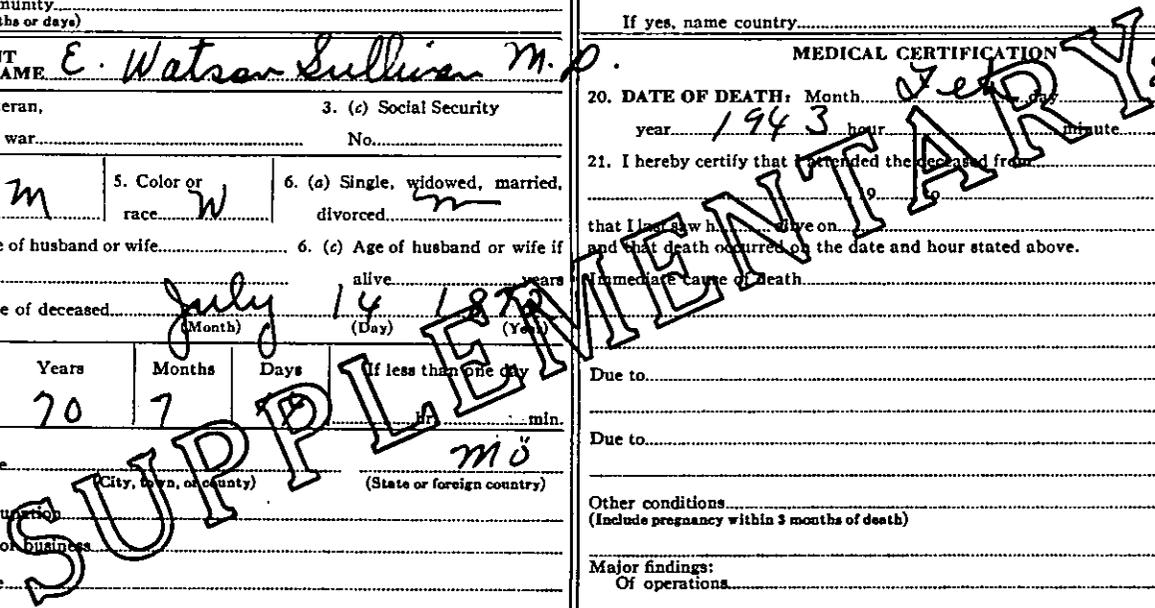
(c) Where did injury occur? _____
(City or town) (County) (State)

(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 _____ (M. D. or other) _____
Date signed _____

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



18211-5