

FILED MAY 15 1943

Registration District No. 20

Primary Registration District No. 5083

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Rural, Mound Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 70 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

(c) City or town Rural, Mound Twp
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Annie E. Sulkerson

3. (b) If veteran, name war ✓

3. (c) Social Security No. —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 11 day _____
year 1943 hour _____ minute 30 P. M.

4. Sex Female 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John F. Sulkerson

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

7. Birth date of deceased Feb 14 - 1845
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 40 years _____, 19 _____, to Mar 11 _____, 1943

that I last saw him alive on February 11 _____, 1943
and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>98</u> | <u>0</u> | <u>25</u> | _____ hr. _____ min. |

Immediate cause of death Coronary Occlusion, Atherosclerosis

Due to Arterio Sclerosis _____ years

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

10. Usual occupation Retired Housewife

Other conditions (Include pregnancy within 3 months of death) 940

11. Industry or business _____

12. Name Adam Painter

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

14. Maiden name Nancy Burns

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

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant Eletcher Sulkerson

(b) Address _____

17. (a) Burial (b) Date thereof 3-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cem

18. (a) Signature of funeral director Creath & Sis

(b) Address Adrian Mo

19. (a) Burial (b) Adrian Mo
(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 E. E. Robinson (M. D. or other) _____
Address Adrian Mo Date signed 3-14-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1295

RECEIVED

District Health Officer No. 71
District File Number 4-43-453
Date Filed 6-14-43

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 and

Fred I. Gneath #3343

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3650

P. O. Address Adrian 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. 13608
Registrar's No. _____

Registration District No. 20

Primary Registration District No. 5-083

1. PLACE OF DEATH:

(a) County Bates
(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) 70 yrs

3. (a) PRINT FULL NAME Aunie E. Fulkerson

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

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

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

7. Birth date of deceased Feb 14 - 1845
(Month) (Day) (Year)

8. AGE: Years 98 Months _____ Days _____ (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 Adrian, Mo.

17. (a) _____ (Burial, cremation, or removal) (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 Mo (b) County Bates
(c) City or town Rural
(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 _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____

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) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

