

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 18657

FILED JUN 3 1944

Registration District No. 2294 Primary Registration District No. 3043

Registrar's No. 165

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1. PLACE OF DEATH:

(a) County: Marion

(b) City or town: Hannibal
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Marion

(c) City or town: Hannibal
(If outside city or town limits, write "RURAL")

(d) Street No.: 836 Grand Avenue
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME: Daniel J. Sughru

3. (b) If veteran, name war: World War I

3. (c) Social Security No: 486-12-5788

4. Sex: Male 5. Color or race: White

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

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

7. Birth date of deceased: September 23, 1896
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>7</u>	<u>14</u>	hr. min.

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

10. Usual occupation: laborer

11. Industry or business _____

12. Name: John Sughru

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

14. Maiden name: Mary A. Crawford

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

16. (a) Informant: John Sughru

(b) Address: 307 North St Hannibal MO

17. (a) Burial (b) Date thereof: May-9-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary's Cemetery

18. (a) Signature of funeral director: James Polineel

(b) Address: Hannibal MO

19. (a) 5-12-44 (b) R J Connor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Suffocation, from being caught in burning house

Due to: After talking to family and viewing the building where death occurred I deemed an inquest unnecessary

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) Accident

(b) Date of occurrence: 5/7/44

(c) Where did injury occur? Home
(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: Wm M Smith (M.D.) Coroner
Address: 902 Broadway Hannibal Date signed: 5/8/44

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

99
5/8/44

1146

JUN 12 1944

AUG 18 1944

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

Michael J. O'Connell

Licensed Embalmer No. 3246

P. O. Address *Annita S. 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.