

FILED JUL 28 1944
Registration District No. 383

State File No. _____
Registrar's No. 101

Primary Registration District No. 5653

1. PLACE OF DEATH:

(a) County Louise
(b) City or town Osberg *LINDA 47*
(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 about 60 year years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Louise
(c) City or town Osberg, Mo *55*
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country _____ *0*

3. (a) PRINT FULL NAME

Mrs. Martha Ann Sutton

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month July day 5th
year 1944 hour 3:10 minute a M.

6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife Frank J. Sutton
7. Birth date of deceased: March 10 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 23
1944 to July 5, 1944
that I last saw her alive on July 3, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 3 Days 25
If less than one day _____ hr. _____ min.

Immediate cause of death apoplexy
Due to Hypertension
Due to _____

9. Birthplace Wright Co. Mo (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 83d

10. Usual occupation At Home

Major findings: Of operations none
Of autopsy none

11. Industry or business Retired Farmers Wife
12. Name John Stephens
13. Birthplace Not known
14. Maiden name Eliza Spalding
15. Birthplace Not known

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
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?
(Specify type of place)
While at work? _____ (e) Means of injury 0

16. (a) Informant Mrs. Wm. Robinson
(b) Address Osberg, Mo
17. (a) Burial (b) Date thereof July 7 1944
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation St. Marys Cemetery
18. (a) Signature of funeral director Geo. S. Orr
(b) Address St. Vernon, Mo

23. Signature P. A. Halmer (M. D. or other) _____
Address St. Vernon, Mo Date signed 7-6-44

MOTHER FATHER

Duration 12 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 144-822

Date Filed 1111 25 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.....

Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address.....

9th & Vernon

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.

Registration District No. 383

Primary Registration District No. 5116

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Hosberg Hosberg Twp
(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

3. (a) PRINT FULL NAME Martha Ann Sutton

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 W

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

7. Birth date of deceased March 10 1889
(Month) (Day) (Year)

8. AGE: Years 73 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 _____

17. (a) Rural (b) Date thereof July 7 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willisburg Cem.

18. (a) Signature of funeral director Wm Werners
(b) Address 707 Werners

19. (a) July 20 44 (b) Andy [Signature]
(Data received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1944 year, 15 hour, 15 minute M.

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

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

Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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) _____
Address _____ Date signed _____

SUPPLEMENTAL

MOTHER FATHER

250103