

FILED OCT 23 1944
299

Registration District No. _____

Primary Registration District No. 6026

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

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Bunker, Mo.
(c) Name of hospital or institution: Barroll Hosp
(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 George Hiram Sullivan

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rachel Sullivan 6. (c) Age of husband or wife if alive 66 1/2 years
7. Birth date of deceased June 23 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 3 27 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Army

MOTHER FATHER
12. Name William Sullivan
13. Birthplace Dont know
14. Maiden name Sarah Jane Kusberg
15. Birthplace Dont know

16. (a) Informant Edward H. Sullivan
(b) Address P.O. Remont, Mo.
17. (a) Burial (b) Date thereof Oct. 21, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bunker, Mo.

18. (a) Signature of funeral director Wagon Heady
(b) Address Bunker, Mo.
19. (a) Oct 20 1944 (b) Mar Evas Mellington
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds
(c) City or town Bunker 90
(If outside city or town limits write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20,
year 1944 hour 10:00 AM minute _____ M.

21. I hereby certify that I attended the deceased from Oct. 15, 1944 to Oct. 20, 1944
that I last saw him alive on Oct. 18, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis ✓
Duration _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underlines 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 L. L. Hanson (M. D. or other) _____
Address Bunker, Mo. Date signed 10-21-44

RECEIVED

District Health Officer No. 5

District File Number. 1044541

Date Filed 10-25-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.)

-Δ If this body is not embalmed, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. _____

Registration District No. 299 Primary Registration District No. 6026

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

1. PLACE OF DEATH:
(a) County Reynolds-
(b) City or town Bunker-cauld
(c) Name of hospital or institution:
surf
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days
3. (a) PRINT FULL NAME George H. Sullivan
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 _____
7. Birth date of deceased June 23 1898
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

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) _____ (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) _____
(Date 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 Oct Day 12 Year 1964 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 _____

35128