

S. No. 2
M-5-43
5-17-39
I X36671

FILED JAN 19 1945

State File No. _____

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 52

1. PLACE OF DEATH:

(a) County Ti. Franklin

(b) City or town Sullivan

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

(d) Length of stay: 5 days In hospital or institution (Specify whether years, months or days)

In this community _____ (Yes or No)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ti. Franklin

(c) City or town Sullivan
(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 Zora B. Glass

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1944 hour 8 minute 15-4 M.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Della

6. (c) Age of husband or wife if alive 5-9 years

7. Birth date of deceased 12-11-1860
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 2 - 1944 to Dec. 15 - 1944 that I last saw him alive on Dec 15 19 44 and that death occurred on the date and hour stated above.

8. AGE: 84 Years 0 Months 4 Days If less than one day hr. min.

Immediate cause of death Zobor Pneumonia 4 days

Due to _____

9. Birthplace Worcester Co Pa
(City, town, or county) (State or foreign country)

10. Usual occupation Government

Other conditions Bronchial Asthma
(Include pregnancy within 3 months of death)

11. Industry or business work

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy 108

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

16. (a) Informant Della Glass

(b) Address 21 - Clair - Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 18 44
(Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director Shirwood W. Mitchell

(b) Address St. Clair, Mo

19. (a) 12-15-44 (Date received local registrar) (b) Dilbert Gillhaus (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 D. S. Mitchell (M. D. or other)

Address 21 - Clair - Date signed 12/15/44

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

046

36
4
0

1121

MAR - 8 1945

JAN 4 1949

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 1-17-45

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 Sherwood W. Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair, 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.