DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Hogg

State File No. 6179

FILED MAR 12 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 134

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

1. PLACE OF DEATH:

(a) County: GREENE

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

(c) Name of hospital or institution: 1371 Roanoke
(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 .....

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No.: 1371 Roanoke
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME: Susannah Catherine Tulloch

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: George H. Tulloch

6. (c) Age of husband or wife if alive: Dec. years

7. Birth date of deceased: April (Month) 16 (Day) 1854 (Year)

8. AGE: Years 90 | Months 10 | Days 0 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: Home

11. Industry or business .....

MOTHER FATHER

12. Name: John Yoder

13. Birthplace: UNK. (City, town, or county) North Carolina (State or foreign country)

14. Maiden name: Sarah Willson

15. Birthplace: UNK. (City, town, or county) Indiana (State or foreign country)

16. (a) Informant: Mrs. Kathryn Parsons

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-18-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Maple Park

18. (a) Signature of funeral director: H. H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 2-19-45 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16 year 1945 hour 9 minute 25 p. m.

21. I hereby certify that I attended the deceased from 2-13-45, 19..., to 2-16-45, 19..., that I last saw him alive on 2-16-45, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia following fractured hip

Due to: Senility 90+

Due to .....

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) .....

(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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature: Garrett Hogg (M. D. or other)

Address: 510 Woodruff Bldg. Date signed: 2-19-45

Spfd., Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Walter E Hamel

Licensed Embalmer No. 3808

P. O. Address Springfield 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 134

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(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)

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

3. (a) PRINT FULL NAME Susannah C. Tulloch

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 April (Month) 16 (Day) 1856 (Year)

8. AGE: Years 90 Months 10 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26 year 1965 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to I did not treat her for fracture - Her Physician was Dr Jas. Horton of Spgfld

Due to

Other conditions Had fractured hip in I believe Dec 4

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 1954

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

6179