

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25250**

FILED 381L 18 1945

Registration District No. **381L**

Primary Registration District No. **6173**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Osage & Rural Bowman
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(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 Mo. (b) County Sullivan ¹⁰⁵

(c) City or town Osage Rural
(If outside city or town limits, write "RURAL") ⁰

(d) Street No. _____ (If rural, give location) ⁰

(e) Citizen of foreign country? No (Yes or No) ⁰

If yes, name country _____

3. (a) PRINT FULL NAME George Sykes

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10th day 31st year 1944 hour 1 minute _____ P.M.

21. I hereby certify that I attended the deceased from 10-22- 1944 to 10-31- 1944; that I last saw him alive on 10-29- 1944 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: 9 5 1809
(Month) (Day) (Year)

Immediate cause of death: Broncho pneumonia Duration 3 da.

Due to Organic heart disease

Due to Metast. neoplasm

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

8. AGE: Years 85 Months 1 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Russell Co Virginia
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy 92 hr

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

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? _____

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Piggins Dan

(b) Address Melan

19. (a) May 45 (b) Mrs. L. D. Green
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. B. Weston (M. D. or other) MD

Address Paer, Mo. Date signed 11-1-44

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

RECEIVED

District Health Officer No. 10

District File Number 7-45-1166

Date Filed JUL-17-1945

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.....

Murl E. Husted

Licensed Embalmer No. 5304

P. O. Address Monroville 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.

no sign

No. 2B
1-3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 1348

Primary Registration District No. (6173)

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Osgood Rural Bowman
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: sup

(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 mo (b) County Sullivan

(c) City or town Osgood Rural
(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 George Sykes

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 Broncho pneumonia

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife Lyla

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

7. Birth date of deceased Sept 5
(Month) (Day) (Year)

Due to organic heart disease

Due to mitral regurg.

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

Major findings: Of operations _____

Of autopsy _____

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

11. Industry or business _____

12. Name William Sykes

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

14. Maiden name Nancy Sykes

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

(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? _____

16. (a) Informant Mrs. Lucian Hurt

(b) Address Osgood mo.

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Reggini son

(b) Address Milam

19. (a) Sept 3, 1945 (Date received local registrar) Greta Caldwell (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature W C Weston (M. D. or other) M D

address Galt Mo Date signed 11-16-45

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

Supplemental

MOTHER FATHER

1945
S-25250