

FILED SEP 23 1945

Registration District No. _____

Primary Registration District No. **4186**

Registrar's No. **28**

1. PLACE OF DEATH:
 (a) County: **FRANKLIN**
 (b) City or town: **SULLIVAN**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **NORTHSIDE 0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 Mos.**
(Specify whether years, months or days)
 In this community **27 Years.**

3. (a) PRINT FULL NAME: JENNIE CLINE
 (b) If veteran, **NO**
 name war: _____
 (c) Social Security No. **NONE**

4. Sex: FEMALE / **5. Color or race: WHITE**
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife: _____
6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: October 20, 1871
(Month) (Day) (Year)

8. AGE:
 Years: **73** Months: **9** Days: **29**
 If less than one day: _____ hr. _____ min.

9. Birthplace: BOONE COUNTY IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: Home

12. Name: Joseph P. Ludington
13. Birthplace: Unknown
(City, town, or county) (State or foreign country)
14. Maiden name: Hester Ann Owen
15. Birthplace: McDonough Co. Illinois
(City, town, or county) (State or foreign country)
16. (a) Informant: Kenneth Cline

(b) Address: Sullivan, Missouri.

17. (a) Burial (b) Date thereof: Aug. 20, '45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Sullivan I.O.P.

18. (a) Signature of funeral director: [Signature]
(b) Address: Sullivan, Missouri.

19. (a) [Signature] (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: **MISSOURI** (b) County: **FRANKLIN**
 (c) City or town: **SULLIVAN**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month: August day: 18th
 year: **1945** hour: **2** minute: _____ P. M.

21. I hereby certify that I attended the deceased from June 19, 1945, to Aug 18, 1945; that I last saw her alive on Aug 17, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: uremia
Due to: H. pertussis and myocardial failure
Other conditions: [Signature]
(Include pregnancy within 3 months of death)
Major findings: None
Of operations: [Signature]
Of autopsy: none

Duration: 10 days
8 years
5 years
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) (Means of injury)

23. Signatory: [Signature] (M. D. or other)
Address: Sullivan Mo Date signed: 8/20/45

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

36
4
0

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 9-12-45

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

Edgar W. Laffoon

Licensed Embalmer No.

3894

P. O. Address

Sullivan 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, above space should be left blank.