

**FILED** OCT 4 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 114

Primary Registration District No. 48765146

Registrar's No. 31

1. PLACE OF DEATH: Franklin  
 (a) County Sullivan  
 (b) City or town Sullivan  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: At home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community All her Life years, months or days

3. (a) PRINT FULL NAME Susan Jones  
 3. (b) If veteran, name war no 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Pink Jones 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Aug. 19 1873  
 (Month) (Day) (Year)

8. AGE: Years 72 Months 00 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Anthones Mill, Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_  
 12. Name Wm. H. Summers  
 13. Birthplace Anthones Mill, Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Almyra Traves  
 15. Birthplace Not Known  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Euel Northcott  
 (b) Address Sullivan Mo.

17. (a) Burial (b) Date thereof 9-8-1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Anthones Mill, Mo.

18. (a) Signature of funeral director J. P. Williams  
 (b) Address Sullivan, Mo.

19. (a) 9-8-1945 (b) \_\_\_\_\_  
 (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 Sept day 7 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ A. M.  
 21. I hereby certify that I attended the deceased from Sept 6 to Sept 7 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis  
to myocarditis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations None Of autopsy None  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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)  
 28. Signature J. P. Williams (M. D. or other)  
 Address Sullivan Mo. Date signed 9/8/45

Duration 2  
1  
PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-2-45

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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.....

*J. T. Williams*

Licensed Embalmer No. 427

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1027A  
Registrar's No. 31

Registration District No. 114

Primary Registration District No. 4186

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

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:  
(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 Susan Jones

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 m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Aug 19  
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 Aug 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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Nephritis  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

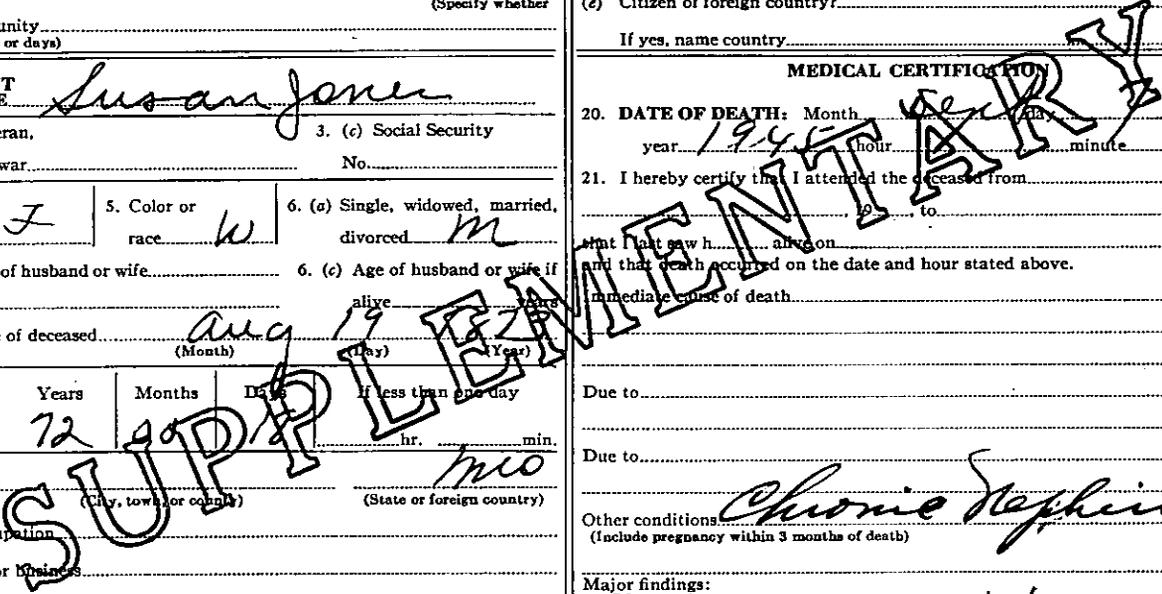
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed \_\_\_\_\_



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