S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 18 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34436

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 170

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1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Woodland Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (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 —

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3. (a) PRINT FULL NAME Sudsberry, Carol Jane
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race Wh.
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept. (Month) 13 (Day) 1945 (Year)

8. AGE: Years — Months — Days 5 If less than one day — hr. — min.

9. Birthplace Moberly (City, town, or county) Mo. (State or foreign country)
10. Usual occupation —
11. Industry or business —
12. FATHER Name Marvin Lavelle Sudsberry
13. FATHER Birthplace Madison (City, town, or county) Mo. (State or foreign country)
14. MOTHER Maiden name Dora Fern Akers
15. MOTHER Birthplace Holliday (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Marvin Sudsberry
(b) Address Madison
17. (a) ~~Holliday~~ Burial (Burial, cremation, or removal) (b) Date thereof 9-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Holliday Mo.
18. (a) Signature of funeral director Speed & Blakey Paris Mo.
(b) Address
19. (a) 9-17-45 (Date received local registrar) (b) Sarah Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 1945
year 2:00 hour — minute P. 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.

	Duration
Immediate cause of death Lobar Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

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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 C. L. Smith (M. D. or other)
Address Moberly, Mo. Date signed 9/17/45

1601 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-45-1594
Date Filed OCT 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.

Not Embalmed

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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.