

DEPARTMENT OF COMMERCE . . . THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

41376

State File No. _____

Registrar's No. 125

Registration District No. 141

Primary Registration District No. 3025

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

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution; West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 hrs.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Andrew Lewis Sukow

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m /
6. (b) Name of husband or wife Mittie Sukow 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased 6 28 1883
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name August Sukow
13. Birthplace Germany
14. Maiden name Martha Stitt
15. Birthplace Canada
(City, town, or county) (State or foreign country)

16. (a) Informant Jack Sukow
(b) Address West Plains

17. (a) _____ (b) Date thereof 11-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evergreen

18. (a) Signature of funeral director Robertsons

(b) Address West Plains, Mo

19. (a) 12-1-1945 (b) Glady's Harrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 16
year 1945 hour 7 minute 05 P.M.

21. I hereby certify that I attended the deceased from 11/16 1945 to 11/16 1945
that I last saw her alive on 11/16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Fractured skull
Crushed pelvis
Due to auto accident

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) accident
(b) Date of occurrence 11/16/45
(c) Where did injury occur? West Plains, Howell Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on Highway Mo. Ave West Plains Mo
While at work? no (Specify type of place) (e) Means of injury Auto accident

23. Signature Walter Thompson (M. D. or other) MD
Address West Plains Mo Date signed 11/20/45

RECEIVED

District Health Officer No 5,

District File Number

72 45 461

Date Filed

12 29 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

W. W. Robertson

Licensed Embalmer No.

3435

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.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Andrew L. Sukow

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June 28, 1883
(Month) (Day) (Year)

8. AGE: Years Months Days (Less than one day) 62 hr. min.

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

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) (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)

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..... year..... 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.....

State Highway Patrol;
Collision with other motor vehicle
Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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?..... (c) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

41376