

FILED FEB 4 1946

Registration District No. 114

Primary Registration District No. 486

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: North Side Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days (Specify whether  
In this community Life years, months or days)

3. (a) PRINT FULL NAME GENE EDWARD HAPPEL

3. (b) If veteran, name war No 3. (c) Social Security No. 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 44 years  
7. Birth date of deceased 10-13-1944  
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 1 If less than one day  
hr. min.

9. Birthplace Cuba (City, town, or county) Mo. in (State or foreign country)

10. Usual occupation Infant

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

MOTHER FATHER  
12. Name Samuel E. Happel  
13. Birthplace Miss Co. Mo (City, town, or county) (State or foreign country)  
14. Maiden name Esther C. Begg  
15. Birthplace Salem Mo (City, town, or county) (State or foreign country)

16. (a) Informant Samuel E. Happel  
(b) Address Cuba Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Cuba Mo

18. (a) Signature of funeral director Edging

(b) Address Courton Mo

19. (a) 1-16-46 (Date received local registrar) (b) U. H. Barlow (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin  
(c) City or town Cuba "Rural"  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15<sup>th</sup>  
year 1946 hour 1 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from January 15<sup>th</sup>  
1946 to January 15<sup>th</sup> 1946  
that I last saw him alive on January 15<sup>th</sup> 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia  
Duration 5 days

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy 107

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? \_\_\_\_\_

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

23. Signature Samuel R. Barlow (M. D. or other) \_\_\_\_\_  
Address Sullivan, Mo. Date signed 1-16-46

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

557

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed

22-46

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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

*Albert Edging*

Licensed Embalmer No.

3504

P. O. Address

*Bowdon Ma*

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.