

No. 2
8-43
17-39
X37823

FILED MAR 14 1946

Registration District No. _____ Primary Registration District No. 4784

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 1 DAY (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County FRANKLIN

(c) City or town SULLIVAN
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ARLINE MAY SOHN

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

4. Sex FEMALE 5. Color or race WHITE

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: FEB 6 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 hr. 15 min.

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

10. Usual occupation None

11. Industry or business _____

12. Name GLEN SOHN

13. Birthplace ST. CLAIR MO
(City, town, or county) (State or foreign country)

14. Maiden name SILBEN WILCOX

15. Birthplace COLO. 1
(City, town, or county) (State or foreign country)

16. (a) Informant GLEN SOHN

(b) Address ST. CLAIR, MO

17. (a) BURIAL (b) Date thereof FEB 9 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. CLAIR, MO.

18. (a) Signature of funeral director Chas. A. Rind

(b) Address St. Clair Mo

19. (a) 4/8/46 (b) Ch. Prout
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 7
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 2/7/46 to 2/7/46, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Heart
Due to _____

Due to _____

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

Major findings:
Of operations 1572
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury D

23. Signature Dr. Prout (M: D. or other)
Address St. Clair Mo Date signed 2/8/46

Duration

1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

4157

RECEIVED

District Health Officer No. 9;

District File Number.....

Date Filed 3-1-46

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.....

Not embalmed.

.....; Registered Apprentice No.....

working under my personal supervision.

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.