

FILED JUL 29 1946

Registration District No. **22** Primary Registration District No. **1000** Registrar's No. **682**

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **State Hospital # 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 hr. 1 hr.**
(Specify whether years, months or days) **1 yr. 1 da.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

(c) City or town **Gardnerville**
(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 **Anna HEE Suddath**

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 **2**

6. (b) Name of husband or wife **---** 6. (c) Age of husband or wife if alive **27** years (Day) (Year)

7. Birth date of deceased **Fla 27 1865**
(Month) (Day) (Year)

8. AGE: Years **81** Months **3** Days **25** If less than one day **---** hr. **---** min.

9. Birthplace **Boswell Mo**
(City, town or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Mr. Overland**

13. Birthplace **Fla** (City, town, or county) (State or foreign country)

14. Maiden name **Cartwright**

15. Birthplace **Fla** (City, town, or county) (State or foreign country)

16. (a) Informant **James Suddath**

(b) Address **Gardnerville Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 18, 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **near Seale, Mo**

18. (a) Signature of funeral director **E. R. Coyne**

(b) Address **Seale, Mo**

19. (a) **June 17, 1946** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **6** day **16** year **1946** hour **3** minute **16** M.

21. I hereby certify that I attended the deceased from **6/14** 19**46**; that I last saw her alive on **6/16** 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Apoplexy**

Due to **Stroke**

Due to _____

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

PHYSICIAN

Major findings: Of operations **270**

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) (e) Means of injury **---**

23. Signature **[Signature]** (M. D. or other) Address **Seale, Mo** Date signed **6/16/46**

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

18452

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..... *A. H. George*
Licensed Embalmer No. *3645-*
P. O. Address..... *Greenwood, Md.*

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.