

FILED AUG 8 1946

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 353

Primary Registration District No. 6195

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Leavenworth
(b) City or town Kinderpost, Mo.
(c) Name of hospital or institution:
near Kinderpost, Mo.
(d) Length of stay: In hospital or institution 7 hours
In this community 7 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas
(c) City or town Kinderpost, Mo.
(d) Street No. near Kinderpost, Mo.
(e) Citizen of foreign country? X

3. (a) PRINT FULL NAME Annamed Sullens

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 0

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

7. Birth date of deceased July 12 1946

8. AGE: Years _____ Months _____ Days _____ If less than one day 7 1/2 hr. 12 min.

9. Birthplace Kinderpost, Mo.

10. Usual occupation Infant

11. Industry or business _____

12. Name Clabe Sullens

13. Birthplace Mo.

14. Maiden name Maie Skidmore

15. Birthplace Evans, Mo.

16. (a) Informant Clabe Sullens

17. (a) Burial Graddock Cem. (b) Date thereof 7, 13, 46

18. (a) Signature of funeral director neighbors (b) Address Kinderpost, Mo.

19. (a) 7-23-46 (b) E. Luora Nasse

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 46 hour 4 P.M. minute 12 M.

21. I hereby certify that I attended the deceased from July 12 1946 to July 12 1946
that I last saw him alive on July 12 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

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) no

(b) Date of occurrence ✓

(c) Where did injury occur? ✓

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature L. S. Paudal (M. D. or other) 0

Address Dickinson Date signed 7-22-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

24877

700

RECEIVED

District Health Officer No. 5,

District File Number 846446

Date Filed 8-15-46

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.....

....., 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.