

No. 2  
17-39  
117-57823

FILED DEC 11 1946

Registration District No. **349**

Primary Registration District No. **6180**

Registrar's No. **4**

1. PLACE OF DEATH:

(a) County **Sullivan**  
(b) City or town **Rural --- Morriss Twp.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Home --- Morriss Twp. / Sullivan Co.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community **Life**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Sullivan 105**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Morriss Twp.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Alice Riddle**

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

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

6. (b) Name of husband or wife **Lee Riddle**  
6. (c) Age of husband or wife if alive **81** years

7. Birth date of deceased **November 25 1874**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>71</b>	<b>11</b>	<b>19</b>	hr. min.

9. Birthplace **Sullivan Co. Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **William Morriss**

13. Birthplace **Sullivan Co. Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Coffman**

15. Birthplace **Putnam Co. Indiana**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. M. S. Ball**  
(b) Address **Cor. Missouri**

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

(c) Place: burial or cremation **Opesco Cem.**

18. (a) Signature of funeral director **Alvin E. Kent & Son**  
(b) Address **Green City Missouri**

19. (a) **11-29-46** (b) **Jama Shan**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **14**  
year **1946** hour **5** minute **P M.**

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial pneumonia**  
Duration **24 h**

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

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

Other conditions **Intermittent fever 7 days**  
(Include pregnancy within 3 months of death)  
**Cerebral splenitis**

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(c) 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) (c) Means of injury **0**

23. Signature **J. P. McArthur** (M. D. or other)

Address **Browning Mo** Date signed **11-46**

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

MOTHER FATHER

MAY 22 1950

MAY 19 1950

RECEIVED  
District Health Officer No. 10  
District File Number 12-46-2238  
Date filed DEC 10 1946

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 Glen E. Kent

Licensed Embalmer No. 1769

P. O. Address Green City Mo

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. 349

Primary Registration District No. 6180

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Abie Riddle

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color W  
race

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased no

(Month)

(Day)

(Year)

8. AGE:

Years 21

Months 11

Days 4

(Less than one day)

hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-29-46 (b) Laura Shaw

(Date received local registrar)

(Registrar's signature) deputy

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 \_\_\_\_\_ Day \_\_\_\_\_  
Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

39373