

FILED JAN 9 1947

Registration District No. 76Primary Registration District No. 5302

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Eugene, R.R. 1
 (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 Life
 years, months or days

3. (a) PRINT FULL NAME George Walter Sullens3. (b) If veteran, name war --- 3. (c) Social Security No. ---4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Mary Theresa 6. (c) Age of husband or wife 78 years7. Birth date of deceased Oct. 3rd 1862
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
84 2 20 hr. min.9. Birthplace Brazito, Cole, Co. Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name P. W. G. Sullens13. Birthplace Ky.
(City, town, or county) (State or foreign country)14. Maiden name Salina Johnston15. Birthplace Ky.
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Mary Sullins(b) Address Eugene, Mo.17. (a) Burial (b) Date thereof Dec. 25, 46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt. Carmel Cem.18. (a) Signature of funeral director Walter L. Lester(b) Address Russellville, Mo.19. (a) 1-17-47 (b) W. J. Glaver
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23 1946
year hour 6 minute 50 A.M.21. I hereby certify that I attended the deceased from Jan. 1, 1946, to Dec. 23, 1946
that I last saw him alive on Dec. 15, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Carcinoma of Stomach 8 yrs

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? _____

(Specify type of place) _____

(e) Means of injury _____

23. Signature Walter L. Lester (M. D. or other) _____Address Russellville, Mo. Date signed 12-24-46

2 No
3-M
1 x

Date Filed 1-8-47

District File Number _____

District Health Officer No. 9,

RECEIVED

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 Hugh Schubert

Licensed Embalmer No. 2820

P. O. Address Russellville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan 2
Registrar's No. 2

Registration District No. 76 Primary Registration District No. 5302

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

1. PLACE OF DEATH:

(a) County cole
(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 George W. Sullivan

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased oct 3 (Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____
FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) January 17-1947 (Date received local registrar) (b) Mr. T. L. Glavin (Registrar's signature)

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 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

40032