

S. No. 2
DM-5-43,
v. 5-17-39
I X36671

FILED APR 8 1947
Registration District No. **182**

Primary Registration District No. **5681**

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

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Rural Monteville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

(c) City or town Rural
(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 Infant 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** S O

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

7. Birth date of deceased March 19 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>4</u> hr. _____ min.

9. Birthplace Linn County 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name J. T. Sullivan

13. Birthplace Chariton County Mo
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Brown

15. Birthplace Monteville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant J. T. Sullivan

(b) Address St. J. P. Brookfield

17. (a) Burial **(b) Date thereof** Mar 19 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Michael Cemetery

18. (a) Signature of funeral director Bowden Funeral Home

(b) Address Brookfield Mo.

19. (a) Date received local registrar Mar 21 1947 **(b) Registrar's signature** Mrs. R. Kelley

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 18
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 3/18, 1947, to 3/18, 1947;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature **Duration** _____

Due to _____

Due to _____

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

Major findings: 159

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? _____ **(c) Means of injury** 2

23. Signature L. C. Smith R.O. (M. D. or other) _____

Address Brookfield Mo. **Date signed** 3/19

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.

Not Embalmed

Signed.....

Jamer B. McClard

Licensed Embalmer No. 4230

P. O. Address Brookfield, 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.