

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23854
Registrar's No. 24

Registration District No. Primary Registration District No. 486

36
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County FRANKLIN
(b) City or town SULLIVAN
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution:
135 ELM
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year (Specify whether years, months or days)

3. (a) PRINT FULL NAME JANE ELLEN STOODS
3. (b) If veteran, name war (c) Social Security No. No.
4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced SINGLED
6. (b) Name of husband or wife (c) Age of husband or wife if alive 6 years
7. Birth date of deceased MARCH 24 45 (Month) (Day) (Year)

8. AGE: Years 2 Months 4 Days 1 If less than one day hr. min.

9. Birthplace PROVIDENCE R. ISLAND (City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business

12. Name FRED STOODS

13. Birthplace ST. LOUIS MO (City, town, or county) (State or foreign country)

14. Maiden name GERTRUDE RILEY

15. Birthplace CRANSTON Rhode Island (City, town, or county) (State or foreign country)

16. (a) Informant GERTRUDE STOODS

(b) Address SULLIVAN, MO

17. (a) BURIAL (b) Date thereof JULY 27, 1947 (Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. CEM Sullivan

18. (a) Signature of funeral director J. Williams

(b) Address SULLIVAN, MO

19. (a) 7-27-47 (b) [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County FRANKLIN 36
(c) City or town SULLIVAN 4
(If outside city or town limits, write "RURAL")
(d) Street No. 135 ELM (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 25 year 1947 hour 7 minute P M.
21. I hereby certify that I attended the deceased from 1946 to 7-25-1947 that I last saw her alive on July 25, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia, Sternum - laceration
Due to: [Signature]
Due to: [Signature]
Other conditions: (Include pregnancy within 3 months of death)

Major findings: July 1946 Of operations: Breast tumor 1 year post
Of autopsy: none
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) Means of injury
23. Signature [Signature] (M. D. or other) Address Sullivan, Mo Date signed 7/27/47

Date Filed 8-8-47
District File Number 8-8-47

District Health Officer No. 9,

RECEIVED
JUL 25 1947

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STATEMENT BY LICENSED EMBALMER

0245

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by:

Harmon D. Harris

Registered Apprentice No. 475

working under my personal supervision.

Signed

Lloyd W. Brown

Licensed Embalmer No. 7374

P. O. Address: Sullivan 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.)

RECEIVED
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If this body is not embalmed, fact should be so stated above.