

WRITE PLAINLY—USING 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 North Side Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs 50 min
life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Crawford
(c) City or town Cuba
(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 1

3. (a) PRINT FULL NAME Sharon K. Pinnell
3. (b) If veteran, no name war
3. (c) Social Security No. none

4. Sex F Color or race W
6. (a) Single, widowed, married, divorced, single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 29, 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 hr. 50 min.

9. Birthplace Sullivan, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business
12. Name Jas. Raymond Pinnell
13. Birthplace Cuba, Mo
(City, town, or county) (State or foreign country)
14. Maiden name Barbara June Stine
15. Birthplace Overland, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jas Pinnell
(b) Address Cuba, Mo
17. (a) Burial (b) Date thereof Dec 30, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cuba, Mo

18. (a) Signature of funeral director None
(b) Address Dec 30, '47
19. (a) Dec 30, '47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1947 hour 9 minute 40p M.
21. I hereby certify that I attended the deceased from Dec 29, 1947, to Dec 29, 1947;
that I last saw h. or alive on Dec 29, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage 3 hours
Due to injury at birth, breech extraction

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations [Signature]
Of autopsy
PHYSICIAN
Underline the cause of 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)
While at work? (e) Means of injury
23. Signature [Signature] (M. D. or other) [Signature]
Address Sullivan, Mo Date signed 12/30/47

RECEIVED
District Health Officer No. 84
District File Number
Date Filed 3/16/48

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.