

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22487**

U.S. National Office of Vital Statistics
FILED AUG 9 1948

Registration District No. **54**

Primary Registration District No. **4097**

Registrar's No. **141**

1. PLACE OF DEATH:
(a) County **Cass**
(b) City or town **Harrisonville Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Harrisonville Memorial Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 hr** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Cass**
(c) City or town **Lataste**
(If outside city or town limits, write "RURAL")
(d) Street No. **1** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **THERESA GAY SULSEA**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **2** year **1948** hour **11:15** minute **P** M.
21. I hereby certify that I attended the deceased from **Aug 2**, 19**48**, to **Aug 2**, 19**48**, that I last saw her **alive on Aug 2** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color **White** 6. (a) Single, widowed, marital, divorced, **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **Aug 2 1948**
(Month) (Day) (Year)

Immediate cause of death **Grandiose**
6 1/2 mo.
Due to **Conditioning spiking from maternal cause**
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: **159**
Of operations
Of autopsy

8. AGE: Years Months Days If less than one day **5 45 min**
9. Birthplace **Harrisonville Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business
12. Name **Franklin Sulsea**
13. Birthplace **Cass Mo**
14. Maiden name **Betty Jo Sloan**
15. Birthplace **Cass Mo**
(City, town, or county) (State or foreign country)

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? (a) Means of injury

16. (a) Informant **Franklin Sulsea**
(b) Address **Lataste Mo**
17. (a) **burial** (b) Date thereof **8-3-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Pleasant Hill**
18. (a) Signature of funeral director **RUNNENBURGER'S**
(b) Address **HARRISONVILLE, MO.**
19. **Aug 3-1948** (Date received local registrar)
(b) **Laura J. Jones** (Registrar's signature)

23. Signature **Karen B. West** (M. D. or other)
Address **Harrisonville, Mo** Date signed **8-3-48**

MOTHER FATHER

PHYSICIAN
Underline the cause of which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{NOT} embalmed by me, or by _____
working under my personal supervision. _____, Registered Apprentice No. _____

Infant - not embalmed

Signed Ernest R. Runnberg
Licensed Embalmer No. 3368
P. O. Address Harrisonville, 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. aug
Registrar's No. 1K1

Registration District No. 59

Primary Registration District No. 4097

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(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 Theresa G. Sulzer

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Aug 2 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (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 FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. Aug. 13, 1948 (b) Laura J. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cass
(c) City or town Raton, Mo.
(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 _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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