FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7144

BIRTH NO. 3 REG. DIST. NO. 347 PRIMARY REG. DIST. NO. 6170 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY: Stone Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 62 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Stone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Galena Mo.
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Mallie b. (Middle) c. (Last) Sims

4. DATE OF DEATH: (Month) Feb (Day) 8 (Year) 49

5. SEX: F
6. COLOR OR RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 14 - 1869
9. AGE (In years last birthday): 79 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): U. S. Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Andy Sullivan
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Mrs Lou Cox

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		Interval between onset and death
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Apoplexy	2 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	arteriscoris	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	334X	

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949, *to* Feb 8, 1949, *that I last saw the deceased alive on* Feb 7, 1949, *and that death occurred at* 5:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hagaury M.D.
23b. ADDRESS: Aurora Mo
23c. DATE SIGNED: Feb 9-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Feb 9-49
24c. NAME OF CEMETERY OR CREMATORY: Ponce-De-Leon
24d. LOCATION (City, town, or county) (State): Ponce-De-Leon Mo

DATE REC'D BY LOCAL REG.: 2/26/49
REGISTRAR'S SIGNATURE: Mrs J. Bruce Brosses 317
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Everett J. Cheatham

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 6,
District File Number 349-272
Date Filed 3-3-49

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_____, Student Embalmer No. _____ working under my personal supervision.

Signed Everett J. Cheatham
Licensed Embalmer No. 3870
P. O. Address Galena Mo

Signed _____
Student Embalmer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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