

FILED JUL 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19085

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>44</u>		PRIMARY REG. DIST. NO. <u>486</u>		Registrar's No. <u>29</u>	
1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MO</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>SULLIVAN</u>		c. LENGTH OF STAY (in this place) <u>3 WKS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>STANTON, MO.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTHSIDE HOSP.</u>				d. STREET ADDRESS (If rural, give location) <u>TWIN SPRINGS RESORT</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u>		b. (Middle) <u>JAMES</u>		c. (Last) <u>DENNY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 22 1949</u>	
5. SEX <u>MO</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>JUNE 22 1902</u>	
9. AGE (In years last birthday) <u>47</u>		10. MONTHS <u>0</u>		11. DAYS <u>0</u>		12. HOURS <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARETAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESORT</u>		11. BIRTHPLACE (State or foreign country) <u>CEPARD HILL, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES V. DENNY</u>		13b. MOTHER'S MAIDEN NAME <u>VERONA POWERS</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 1929-32</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Verona Denny Sullivan</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Auricular fibrillation 18 days</u> and <u>atrial thrombi</u> DUE TO (c) <u>Multiple areas of Phlebotrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>4331</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>May 1, 1949</u> , to <u>6/22, 1949</u> , that I last saw the deceased alive on <u>6/22, 1949</u> , and that death occurred at <u>10:20 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John S. de la Torre M.D.</u>				23b. ADDRESS <u>Sullivan, Mo.</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 24, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ODDFELLOWS</u>		24d. LOCATION (City, town, or county) (State) <u>SULLIVAN, MO</u>	
DATE REC'D BY LOCAL REG. <u>6-23-49</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Harrison</u>		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. H. Eaton Sullivan, Mo.</u>			

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

RECEIVED JUN 27 1949
District Health Officer No. 9,
District File Number

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.

Student
Student Embalmer

Signed

Licensed Embalmer No. 4344

P. O. Address Box 28 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.)

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