

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38355

No. 300

10. 48

FILED NOV 17 1952

BIRTH NO. _____		REG. DIST. NO. <u>128</u>	PRIMARY REG. DIST. NO. <u>2000</u>	Registrar's No. <u>995</u>
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>Randolph</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>5 HRS.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPARTA</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN HOSP.</u>		d. STREET ADDRESS (If rural, give location) <u>X</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>DR. JESSE</u>		b. (Middle) <u>C.</u>	c. (Last) <u>SUTHERLAND</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 6 1952</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 12 1881</u>	9. AGE (In years last birthday) <u>71</u> If under 1 year: Months _____ Days _____ If under 1 min. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>DICKENSON COUNTY, VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>JASPER SUTHERLAND</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISA DYER</u>	14. NAME OF HUSBAND OR WIFE <u>LYDIA SUTHERLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>DR. A.R. SUTHERLAND CLINTWOOD, VA.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Skull Fracture</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>ACCIDENT</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>RURAL WEST PLAINS HOWELL, MISSOURI</u>	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Nov. 6, 1952 3pm</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>ONE CAR ACCIDENT</u>		
22. I hereby certify that I attended the deceased from <u>Nov 6, 1952</u> to <u>Nov 6, 1952</u> , that I last saw the deceased alive on <u>Nov 6, 1952</u> , and that death occurred at <u>11:45pm</u> , from the causes and on the date stated above.				
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>11/7/52</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>11/9/52</u>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <u>FREMONT, VIRGINIA</u>	
DATE REC'D BY LOCAL REG. <u>11-10-52</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. LOHMEYER SPRINGFIELD, MO.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

396
0

DEC 3 1952

NOV 17 1952

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 James T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield

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.