

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **8179**

FILED MAR 22 1957

Registration District No. **114** Primary Registration District No. **4186** Registrar's No. **13**

1. PLACE OF DEATH a. COUNTY FRANKLIN			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY FRANKLIN		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SULLIVAN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SULLIVAN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SARAH ST.		Length of stay in 1b 1 YR.	d. STREET ADDRESS (If outside, give location) SARAH ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FANNIE Middle JANE Last STUDDARD			4. DATE OF DEATH Month MARCH Day 13 Year 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 23, 1896	9. AGE (In years last birthday) 61 IF UNDER 1 YEAR: Months 1 Days 20 Hours Min. IF UNDER 24 HRS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) WASHINGTON Co. O		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES BOYER			14. MOTHER'S MAIDEN NAME MARY ELLEN STUDDARD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address FRANCES O'NEAL ST. LOUIS, MO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia					INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Cerebral Thrombosis					2 wks.
DUE TO (c) Arteriosclerotic Hypertension + Cerebral Artery					Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443x					19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from April 1954 to March 13, 1957 and last saw her ^{her being} alive on March 13-57 Death occurred at 5:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert J. Sullivan, M.D.			22b. ADDRESS Sullivan, Mo.		22c. DATE SIGNED Mar 14-57
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MARCH 16, 1957		BUFFALO CEM.	
24. FUNERAL DIRECTOR H. Weater		ADDRESS Sullivan, Mo.		25. DATE RECD. BY LOCAL REG. 3/15/57	
				26. REGISTRAR'S SIGNATURE Thomas G. Kennedy	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Death, however, must be causally related. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. P. Humphrey*

Licensed Embalmer No. *4770*

P. O. Address *Sullivan*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.