MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-042998
STATE FILE NUMBER

FILED VS NOV 29 1960 267

Registration District No. _____ Primary Registration District No. 4400 Registrar's No. 189

1. PLACE OF DEATH
a. COUNTY: Pemiscot
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Bragg City — Length of stay in 1b: 27 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Bragg City, Mo. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Pemiscot
c. CITY OR TOWN: Bragg City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Sallie Middle: Caroline Last: Sullivan
4. DATE OF DEATH: Month: Nov. Day: 14 Year: 1960
5. SEX: Fem
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6-5-1881
9. AGE (last birthday): 79 — IF UNDER 1 YEAR: Months 5 Days 9 — IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): Texas
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: William Arnold
13b. MOTHER'S MAIDEN NAME: Mary Bouie
14. NAME OF HUSBAND OR WIFE: unknown(deceased)
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.: none
17. INFORMANT: Mrs. Janie Edwards, Bragg City, Mo.

MEDICAL CERTIFICATION

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: 8 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebrovascular accident — 14 mo.
DUE TO (c): ___
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): chronic pyelonephritis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 9/14/59, to 11/14/60 and last saw her alive on 11/14/60
Death occurred at approximately 12:50pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William D. Bryant, M.D.
22b. ADDRESS: Deyti, Mo.
22c. DATE SIGNED: 11/16/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-16-1960
23c. NAME OF CEMETERY OR CREMATORY: Sullivan
23d. LOCATION (City, town, or county) (State): Calomine, Ark.

24. FUNERAL DIRECTOR: McDaniel Funeral Ser. ADDRESS: Kennett, Mo.
25. DATE RECD. BY LOCAL REG.: 11-28-60
26. REGISTRAR'S SIGNATURE: Charlotte E. Sloan

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Tommy L. Doherty

Licensed Embalmer No. 4886

P. O. Address Kennett,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.