

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-010767

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 162

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 22 1963

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Welch Twp.</u> Length of stay in 1b <u>life</u>		c. CITY OR TOWN <u>Advance.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R # 1, Advance, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elmer Sullinger</u>			4. DATE OF DEATH Month Day Year <u>March 14, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-77</u>
9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>5 9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Cape Girardeau Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Larkin Sullinger</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Blocker</u>		14. NAME OF HUSBAND OR WIFE <u>Malinda H. Sullinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Malinda Sullinger, Advance, Mo.</u>		Address <u>R # 1,</u>	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Circulatory Collapse</u>			<u>20 HRS</u>
DUE TO (c) <u>Cerebral Thrombosis</u>			<u>3 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Previous Cerebral Thrombosis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
19. WAS AUTOPSY PERFORMED? 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.) <u>None</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>2:30 P</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Advance Mo.</u>	
21. I attended the deceased from <u>Sept 1-58</u> to <u>3-14-63</u> and last saw him alive on <u>3-14-63</u> Death occurred at <u>2:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>La Mestas D.D.</u>		22b. ADDRESS <u>Advance Mo</u>	22c. DATE SIGNED <u>3-15-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-18-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>
23d. LOCATION (City, town, or county) <u>R # 1, Advance, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Wm. H. Morgan, Advance, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-19-63</u>	
26. REGISTRAR'S SIGNATURE <u>Ernest Kasten</u>			

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed W^m H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.