

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

1 X1865

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K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D APR 19 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11780
Do not use this space.

1. PLACE OF DEATH
 (a) County Demarest Registration District No. 801
 (b) Township Carethersville Primary Registration District No. 4388
 (c) City Carethersville (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Comadore T. Suddarth
 (a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 26, 1879

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>1</u>	<u>10</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 9. Industry or business in which work was done, as saw mill, bank, etc. State Dept.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dexter Indiana

FATHER

13. NAME Louis Suddarth
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER

15. MAIDEN NAME Hettie Wilkerson
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Mrs W. L. Bennett Carethersville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Carethersville Mo. DATE 3 17 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. F. Long, Imp. Co. Carethersville, Mo.

20. FILED April 1, 1939 Ada Martin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1939, to March 6, 1939
 I last saw him alive on March 6, 1939. Death is said to have occurred on the date stated above, at 5:00 p.m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia, lobar Date of onset _____
 Other contributory causes of importance: Influenza

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no.
 If so, specify _____
 (Signed) G. W. Shippe M. D.
595 (Address) Carethersville, Mo.

RECEIVED

District Health Officer No. 3,

District File Number 39-264

Date Filed 4-10-39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.