No. 2
11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28933

Registration District No. 470 Primary Registration District No. 5633 Registrar's No. 100

1. PLACE OF DEATH:

(a) County Lawrence - F.W.

(b) City or town Mt Vernon

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 868 days (Specify whether

In this community 868 days - years, months or days) 350

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph Mo

(If outside city or town limits write "RURAL")

(d) Street No. Route 1

(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Joseph Sutton

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 3d (Month) (Day) 1915 (Year)

8. AGE: Years 25 Months 2 Days 15 If less than one day ..... hr. ..... min.

9. Birthplace Elwood (City, town, or county) Kansas (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Reed Sutton
13. Birthplace Stanberry (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Melissa Author
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Michael Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 19-1940 (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph

18. (a) Signature of funeral director Geo B Ou 421

(b) Address Mt Vernon Mo

19. (a) Aug 19-1940 (Date received local registrar) (b) Dr R A Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18 year 1940 hour 1:15 minute P M.

21. I hereby certify that I attended the deceased from April 2d, 1938, to Aug 18, 1940 that I last saw him alive on Aug 18, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Far Advanced Bilateral Pulmonary Tuberculosis	4 1/2 yrs
Due to	
Due to	
Other conditions: Left Spontaneous Pneumothorax (Include pregnancy within 3 months of death)	1 mo.

Major findings:
Of operations
Of autopsy Pulmonary Tuberculosis - Left pyo-pneumothorax

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature James W Brain (M. D. or other) MD

Address Mt Vernon Date signed Aug 18 1940

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 940-2541
Date Filed SEP 6 1940

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 George B Ow

Licensed Embalmer No. 946

P. O. Address Mt Vernon S

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.