

REC'D OCT 10 1940

Registration District No. 449

Primary Registration District No. 5618

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

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

(c) Name of hospital or institution:

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

(d) Length of stay: In hospital or institution 2
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME John Neute Sullivan

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Mrs J. N. Sullivan

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

7. Birth date of deceased: Dec 10 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)

10. Usual occupation Farming 9

11. Industry or business _____

MOTHER FATHER

12. Name John Sullivan

13. Birthplace Dont Know
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Otto Sullivan

(b) Address 4852 Minnie Ave Ocean Beach

17. (a) Rural (b) Date thereof 9/19/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads

18. (a) Signature of funeral director none

(b) Address 404

19. (a) 9-20-40 (b) J. M. Coub
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Rural Bray
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
year 1940 hour 1 minute 50 P M.

21. I hereby certify that I attended the deceased from 9-17, 1940 to 9-18, 1940;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death terminal pneumonia

Duration _____

Due to 45 ectomy

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. M. Coub (M. D. or other) !

Address _____ Date signed _____

N. 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

1940-1941

17c

DEPT. OF HEALTH

RECEIVED
District Health Officer No. 7,
District File Number 10-40-1371
Date Filed 10-7-40

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.....

No Embalming, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32378**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **449**

Primary Registration District No. **5618**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Laclede**

(b) City or town **Osage Twp**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

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

In this community _____ (Specify whether _____)

3. (a) PRINT FULL NAME **John Neute Sullivan**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m**

5. Color of race **w**

6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
75	9	9	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **11-20-40** (Date received local registrar)

(b) **Jam Coult** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 18**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour statgd above.

Immediate cause of death **Terminal pneumonia**

Due to **Dysentery**

Due to **Subar pneumonia**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Jam Coult** (M. D. or other) _____

Address _____ Date signed _____

