

JAN 23 1941

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

Do not use this space.

44004

1. PLACE OF DEATH  
 County Saline Registration District No. 797  
 Township Miami 2 Primary Registration District No. 6040  
 City (No. St. Ward)

2. FULL NAME Alice Hoffman Sullivan  
 (a) Residence, No. St. Ward.  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-15-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
63 - 9 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) at present 11. Total time (years) spent in this occupation 48 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

13. NAME Mrs. Hans

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 13

15. MAIDEN NAME Alice

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 13

17. INFORMANT A. M. Sullivan (ADDRESS) Miami MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE LaSota Mo. DATE 12/23

19. UNDERTAKER Campbell, Russ (ADDRESS) Miami MO.

20. FILED 12-21 1940 Mrs. Arlin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-21 1940

22. I HEREBY CERTIFY, That I attended deceased from 12-20, 1940, to 12-21, 1940  
 I last saw him alive on 12-20, 1940 Death is said to have occurred on the date stated above, at 2 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage Date of onset 12/20/40

Other contributory causes of importance: old

Name of operation none Date of  
 What test confirmed diagnosis? Symptoms 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) B.H. Sullivan M. D.  
 (Address) Miami, Mo.

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

50M-16-22-38 1 X3914

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.

RECEIVED

District Health Officer No. 8,

District File Number

1-8-40

Date Filed

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 44004

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 797

Primary Registration District No. 6040

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Miami  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 63 Months 9 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Dec 22 41 (Date received local registrar) (b) Wm. Saline Hale (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 21 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 B. N. Sullivan (M. D. or other) \_\_\_\_\_

Address Miami Date signed \_\_\_\_\_

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

SUPPLEMENTAL COPY

