

NOV 10 1943 43
Registration District No. 43

Primary Registration District No. 4057

State File No. _____
Registrar's No. 326

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Quinn, Mo
(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 No
In this community since 1883 (Specify whether years, months or days)

3. (a) PRENT FULL NAME Sarah Jane Shull

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

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

7. Birth date of deceased June 16 1959
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 4 11 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name John Smith

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

14. Maiden name Sofia Hussler

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

16. (a) Informant Jane Shull
(b) Address Quinn, Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof 10-30-43
(Month) (Day) (Year)

(c) Place: burial or cremation Quinn Cemetery

18. (a) Signature of funeral director Frank Cotrell
(b) Address Poplar Bluff, Mo.
19. (a) 10-30-43 (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Butler 12
(c) City or town Quinn, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 year 1943 hour 5:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from Oct 24, 1943, to Oct 27, 1943, that I last saw her alive on Oct 26, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to Broncho Pneumonia

Due to _____

Other conditions in
(Include pregnancy within 3 months of death) 107
Major findings: _____
Of operations _____
Of autopsy no

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 Geo. F. Cook (M. D. or other)
Address Quinn, Mo Date signed 10/28/43

Duration 4 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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 W. Greer*

Licensed Embalmer No. *2964*

P. O. Address *Caplar Bluff*

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

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 43

Primary Registration District No. 4057

Registrar's No. 326

1. PLACE OF DEATH:

(a) County Butler
 (b) City or town Quincy
(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

Sarah Jane Skull

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 2 5. Color or race w 6. (a) Single, widowed, married, divorced w

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 84 Months _____ Days _____ Unless than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-30-43 (b) Belle Steind
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day _____
 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____

Due to _____

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) _____
 (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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER, FATHER

34284