

FILED JUN 7 1944

Registration District No. 322

Primary Registration District No. 4472

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: 1
(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 Lusy Cabil Sullivan

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

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

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

7. Birth date of deceased April 14 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>78</u>		<u>1</u>	<u>11</u>	_____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Wm. E. Gauding

13. Birthplace don't know
(City, town, or county) (State or foreign country)

14. Maiden name Polly Ann Furrin

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

16. (a) Informant Mrs. Walter Johnson

(b) Address Miami MO

17. (a) _____ (b) Date thereof 5-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miami Cemetery

18. (a) Signature of funeral director Campbell

(b) Address Miami MO

19. (a) May 29-44 (b) Mrs. John G. Giv
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Saline
(c) City or town Miami
(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 5 day 25
year 1944 hour 7 minute 35 P. M.

21. I hereby certify that I attended the deceased from 5-18, 1944, to 5-25, 1944
that I last saw h. er alive on 5-25 and that death occurred on the date and hour stated above.

Immediate cause of death Central Neurocyte Duration 1 week

Due to chronic nephritis and hypertension 8 years
8 years

Due to _____

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

Major findings: Of operations 131P

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? _____

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

23. Signature A. Sullivan (M. D. or other) M.D.
Address Miami, MO Date signed 5/26/44

1211

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

CT 43
R. 7-39
X35897

RECEIVED

Health Officer No. 8,

6-6-44

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, ~~and~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Joe H. Reiser
Licensed Embalmer No. 1171
P. O. Address Marquette

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, fact should be so stated above.