

**FILED AUG 21 1944 318**

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

**1003**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Missouri Baptist Hospital  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron  
 (c) City or town Arcadia (Rural)  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph A.J. Sutton

3. (b) If veteran, name war None  
 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth Sutton  
 6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased November 26 1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>8</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation Mechanic

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

12. Name William Sutton  
 13. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Margaret Vance  
 15. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nancy Deck  
 (b) Address Pilot Knob, Mo.

17. (a) Burial (b) Date thereof 8-29-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 8 1944 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6  
 year 1944 hour 6:45 minute P. M.

21. I hereby certify that I attended the deceased from 8/6-44 to 8/16-44  
 that I last saw him alive on 8/16-44 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to Ins., C.V.S.

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

Other conditions (Include pregnancy within 3 months of death) 307

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 [Signature] (M.D. or D.O.)

Address 932 N. [Signature] Date signed \_\_\_\_\_

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

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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 *Albert G. Hoppe*.....

Licensed Embalmer No. *2971*.....

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, fact should be so stated above.**