

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13972

FILED APR 26 1945
Registration District No. 20

Primary Registration District No. 3043

Registrar's No. 100

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: 822 Webb St
(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 Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No. 822 WEBB ST 4
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MARY ANN SULTZMAN

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 22
year 1945 hour 12 minute 40 9 M.

21. I hereby certify that I attended the deceased from 1975
_____ 19____ to Mch 22 _____ 1945;
that I last saw her alive on Mch 21 _____ 1945;
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHN V. SULTZMAN 6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

7. Birth date of deceased OCT 14 1864
(Month) (Day) (Year)

Immediate cause of death General Debility of Aged. Duration 15mo

Due to Recurrent cerebral hemorrhage 18mo

Due to Hypertensive Cardiovascular Disease 5yrs

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

8. AGE: Years 80 Months 5 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

Major findings: Of operations _____ (Signature)
Of autopsy _____

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

MOTHER FATHER { 11. Industry or business _____

12. Name FREDERICK RUPP

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

14. Maiden name ELEAZABETH RAEBENBIRT

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

16. (a) Informant Mrs. Melvin Spencer
(b) Address Hannibal

17. (a) Burial (b) Date thereof 3-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. MARY CEMETERY

18. (a) Signature of funeral director JAMES O'DONNILL
(b) Address Hannibal

19. (a) 4-3-45 (b) E. M. Lucke
(Date received local registrar) (Registrar's signature)

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 J. S. Sultzman M.D. (M.D. or other)
Address 115 N. 5th Hannibal Mo Date signed 2/29/45

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.....

Joe Bonnell

Licensed Embalmer No. 2022

P. O. Address..... *Hannibal Mo*

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.