

FILED SEP 12 1945

Registration District No. 376

Primary Registration District No. 3061

Registrar's No. 136

1. PLACE OF DEATH:

(a) County St Francois
(b) City or town Flat River
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
314 Hickory Street
(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 St Francois ⁹⁴
(c) City or town Flat River Mo ⁵
(If outside city or town limits, write "RURAL") ²
(d) Street No. ⁰
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME BERLIN J. SUTTERFIELD

3. (b) If veteran, name war..... 3. (c) Social Security No. 499-03-6453

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Larson Sutterfield 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased May 28 1916
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>27</u>	<u>2</u>	<u>3</u>	hr. <u>0</u> min.

9. Birthplace Summitville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Crope helper

11. Industry or business St Joseph Lead Co.

12. Name Elizabeth Sutterfield
13. Birthplace Reynolds Co Mo ⁶
(City, town, or county) (State or foreign country)
14. Maiden name Little Bailey
15. Birthplace Reynolds Co. Mo ⁰
(City, town, or county) (State or foreign country)

16. (a) Informant Larson Sutterfield

(b) Address Flat River Mo

17. (a) Burial (b) Date thereof 8-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bunker Mo

18. (a) Signature of funeral director E. J. Boyer

(b) Address Desloge Mo

19. (a) 8-29-45 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1st day aug
year 1945 hour 1 minute 35 P. M.
21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Coroner Jerry Threlkeld Duration
unavoidable accident

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident ⁹⁴
(b) Date of occurrence Aug 1, 1945
(c) Where did injury occur Flat River, St Francois, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Industrial place Federal Div. Mines
While at work? yes (Specify type of place) (e) Means of injury Crushed chest
23. Signature Bert Miller (M.D. or other) ^{3 coroner}
Address Farmington, Mo Date signed 8/24/45

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

MOTHER FATHER

1397

RECEIVED

District Health Officer No. 4

District File Number 945-1096

Date Filed 9-10-45

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 C. Z. Boyer

Licensed Embalmer No. 1671

P. O. Address Dunlap 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. SeptRegistrar's No. 136Registration District No. 316Primary Registration District No. 3061

1. PLACE OF DEATH:

- (a) County St. Francois
 (b) City or town Flat River
 (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

Berlin J. Lutterfield

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex

m5. 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.....

7. Birth date of deceased.....

May 28
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

292no

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

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (b)

(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 CERTIFICATE

20. DATE OF DEATH: Month.....
-
- year
- 1945
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
-
- to....., 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..... crushed chestOther 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) accident
 (b) Date of occurrence Aug. 1, 1945
 (c) Where did injury occur? Flat River, St. Francois MO
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Industrial Place, lead mine
 (Specify type of place)

While at work? yes (e) Means of injury: crushed between two pieces of machinery

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

Address..... Date signed Aug. 2, 1945

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

S-28366