

**FILED NOV 8 1945**  
Registration District No. **332**

Primary Registration District No. **4517**

Registrar's No. **5**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**1. PLACE OF DEATH:**  
(a) County Laney  
(b) City or town Branson  
(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  
In this community 10 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME LIVER E 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 George W. Sullivan  
6. (c) Age of husband or wife if alive 26 years (Month) (Day) (Year)

7. Birth date of deceased May 26 1866  
8. AGE: Years 79 Months 7 Days 20 If less than one day by min.

9. Birthplace Adick Rock Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business  
12. Name John Anderson  
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's own signature Mr. George Sullivan  
(b) Address Branson Mo.  
17. (a) Removal (b) Date thereof Oct. 27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calico Rock Ark

18. (a) Signature of funeral director P. O. Helcher  
(b) Address Branson Mo.  
19. (a) Oct. 27 1945 (b) Arthur Brookshire  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Arkansas (b) County 979  
(c) City or town Cather 3  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. — (If rural, give location) —  
(e) If foreign born, how long in U. S. A.? — years.

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month October day 25  
year 1945 hour 11 minutes 5 am.  
21. I hereby certify that I attended the deceased on October 21, 1945, to 11:05, 1945; that I last saw her alive on Oct. 24, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency Duration  
Due to Coronary Artery Sclerosis  
Due to —

Other conditions High Blood Pressure  
(Include pregnancy within 3 months of death)  
Major findings: Cardiac Asthma  
Of operations —  
Of autopsy — 946

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 —  
28. Signature Guy W. Mitchell (M. D. or other)  
Address Branson Mo. Date signed 10/26/45

RECEIVED

District Health Officer No. 6

District File Num. 1145-1058

Date Filed NOV 5 1945

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 *Minnie L. Welchel*

Licensed Embalmer No. *2277*

P. O. Address *Branson 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, above space should be left blank.