. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 14 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42587

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 197

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall
(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 7 weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline 97

(c) City or town Marshall 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country —

3. (a) PRINT FULL NAME Thomas Sullivan

3. (b) If veteran, name war — —

3. (c) Social Security No. 2

4. Sex Male 0

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 May (Month) 4 (Day) 1856 (Year)

8. AGE: Years 89 Months 7 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Miami (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Fruit Buyer

11. Industry or business

FATHER
12. Name Samuel W. Sullivan
13. Birthplace — (City, town, or county) Va (State or foreign country) 1

MOTHER
14. Maiden name Katherine Keifer
15. Birthplace Miami (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant S. W. Sullivan
(b) Address Buckline Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Ethel Mo

18. (a) Signature of funeral director Larson Funeral Service
(b) Address Ethel Mo

19. (a) Dec. 25, 1945 (Date received local registrar) (b) Mrs T. O. Westbrook (Registrar's signature)

1215

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1945 hour 1 minute 15 a. M.

21. I hereby certify that I attended the deceased from Dec. 3, 1945, to Dec. 23, 1945; that I last saw him alive on Dec 23, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	36 h.
Due to Retention Urinary	30 days
Due to Hyperprostated Probably Causes?	unknown
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 51 b	
Of autopsy None	

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) None

(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 Mrs E. Lockwood (M. D. or other)

Address 306 N. Main St. Date signed 1/24/45

States Mo 0

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-18-46

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 R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, 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.