

FILED JUN 12 1946

State File No.

Registrar's No.

Registration District No. 20

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Narrival
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. Elizabeth 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 Mo (b) County Marion
(c) City or town Narrival
(If outside city or town limits, write "RURAL")
(d) Street No. 412 Porter St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth M. 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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 12, 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Ireland (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Floxy Sullivan
13. Birthplace _____ (City, town, or county) Ireland (State or foreign country)
14. Maiden name Elizabeth Sullivan
15. Birthplace _____ (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Bernie Childs

(b) Address 255 E. 5th St. Hannibal Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary, Gen Tery

18. (a) Signature of funeral director James O'Connell

(b) Address Hannibal

19. (a) 4-25-46 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 11 year 1946 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Apr 10-46 to Apr 11, 1946 that I last saw him alive on Apr 11, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular - Renal
Due to pleurisy

Due to _____
Other 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) _____
(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 Dr E M Lucke (M. D. Physician)
Address Hannibal Mo Date signed Apr 12

Duration 7
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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..... *A. M. O'Hannell*

Licensed Embalmer No..... *3889*

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.