

No. 2  
5-42  
17-30  
X32873

**FILED SEP 18 1946** STANDARD CERTIFICATE OF DEATH

State File No. **29945**

Registration District No. **114**

Primary Registration District No. **486**

Registrar's No. **90**

**1. PLACE OF DEATH:**  
 (a) County **FRANKLIN**  
 (b) City or town **SULLIVAN, MO.**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**AT HOME**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **8 years** (Specify whether years, months or days)  
 In this community \_\_\_\_\_

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **MO** (b) County **FRANKLIN**  
 (c) City or town **SULLIVAN**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? **NO** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **ELLEN M. BIVIN**  
 3. (b) If veteran, name war **NONE**  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **SEPT** day **9**  
 year **1946** hour **10** minute **A.M.**

4. Sex **F** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **MARRIED**  
 6. (b) Name of husband or wife **JOHN R. BIVIN**  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **MAY 15 1881**  
 (Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from**  
**JAN 26, 1946, to SEPT 9, 1946**  
 that I last saw her alive on **SEPT 9, 1946**  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years **85** Months **3** Days **25**  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Cerebral hemorrhage**  
 Due to **rupture of cerebral vessel**  
 Due to **hypertension**

**9. Birthplace** **RISING SUN INDIANA**  
 (City, town, or county) (State or foreign country)  
**10. Usual occupation** **HOUSEWIFE**

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

**11. Industry or business** **HOME**  
**12. Name** **GROVE**  
**13. Birthplace** \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** \_\_\_\_\_  
**15. Birthplace** \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

**Major findings:** \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**16. (a) Informant** **J. Williams**  
 (b) Address **Sullivan, MO**  
**17. (a) BURIAL** (b) Date thereof **SEPT 11 1946**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**22. If death was due to external causes, fill in the following:**

(c) Place: burial or cremation **100F Cem Sullivan MO**  
**18. (a) Signature of funeral director** **A. J. Williams**  
 (b) Address **Box 111 Sullivan, MO**  
**19. (a) 9-11-46** (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

(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** **A. W. Taylor** (M.D. or other) **D.D.**  
 Address **Sullivan, MO** Date signed **9-13-46**

**Duration**  
**3 days**  
**3 days**  
**years**  
**PHYSICIAN**  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number 9-46-438  
Date Filed 9-17-46

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 Lloyd W. Olson  
Licensed Embalmer No. 4344  
P. O. Address Sullivan 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. OctRegistration District No. 114Primary Registration District No. 4186Registrar's No. 90

## 1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Sullivan  
(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 Ellen M. Bloin

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 15  
(Month) (Day) (Year)8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.)9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) Ind.

## 10. Usual occupation \_\_\_\_\_

## 11. Industry or business \_\_\_\_\_

12. Name Sullivan13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)14. Maiden name Sullivan15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)16. (a) Informant J. Sullivan(b) Address Sullivan Ind.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) 10-7-46 (b) [Signature]  
(Date received local certificate) (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 CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

## Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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) \_\_\_\_\_

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

29945