

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
X36871

FILED APR 24 1947

Registration District No. 113 Primary Registration District No. 4186

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Sullivan

(c) Name of hospital or institution: North Sullivan Hospital  
216 North Church St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day  
(Specify whether Life)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME Norman Wayne Roehrs

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife XX

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased April 17 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 0 1 hr. min.

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

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER

12. Name Marion Roehrs

13. Birthplace Sullivan, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Frances Squires

15. Birthplace Sullivan, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Marion Squires

(b) Address Sullivan, Mo.

17. (a) Burial (b) Date thereof April 18/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Sullivan, Mo.

18. (a) Signature of funeral director W. J. Stoffer

(b) Address 65N. Clark, Sullivan, Mo.

19. (a) 4-18-47 (b) Ed. Roehrs  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin 36

(c) City or town Sullivan 4  
(If outside city or town limits, write "RURAL") 0

(d) Street No. 0  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18  
year 1947 hour 2 minute 00 a.m.

21. I hereby certify that I attended the deceased from 4-17- 1947 to 4-18- 1947  
that I last saw him alive on 4-17- 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia with 6 mva -

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: 57

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 0

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

Address Sullivan Date signed 4/18/47

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 4-23-67

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.....  
Was not embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed Robert M. Murray  
Licensed Embalmer No. 3749  
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.