

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 21 1947

Registration District No. _____

Primary Registration District No. 45-15

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milam
(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 70 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Milam
(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 _____

3. (a) PRINT FULL NAME Core Eleanor Ryan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Timothy Ryan 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased Mar 11 1862
(Month) (Day) (Year)

8. AGE: Years 85 Months 6 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Bary (City, town, or county) Ill (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name George Fusselman
13. Birthplace Nahsburg Penn (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Hart
15. Birthplace Mansfield Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mone Lippert
(b) Address Milam, Mo

17. (a) Burial (b) Date thereof Sept 25 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director Huggins & Son
(b) Address Milam, Mo

19. (a) Oct. 13 - 1947 (b) Mrs. H. B. Harris
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1947 hour 10 minute 40 PM

21. I hereby certify that I attended the deceased from May 6, 1947, to Sept 25, 1947, that I last saw her alive on Sept 25, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
(Signature) [Signature]

Due to Hypertension
arteriosclerotic

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 J. S. Montgomery (M. D. or other) _____
Address Milam, Mo Date signed _____

Duration about 7 Mo.
(Signature) [Signature]

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. 10
District File Number 10-42-1430
Date Filed OCT 20 1947

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 Dwight Legger

Licensed Embalmer No. 3792

P. O. Address Milan 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.