

FILED MAY 24 1949 THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 14849

BIRTH NO. _____ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 4044 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY BOONE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BOONE	
b. CITY (If outside corporate limits, write RURAL and give township) STURGEON		c. CITY (If outside corporate limits, write RURAL and give township) STURGEON	
d. FULL NAME OF HOSPITAL OR INSTITUTION "City"		d. STREET ADDRESS "City"	

3. NAME OF DECEASED (Type or Print) a. (First) NELLIE b. (Middle) K. c. (Last) SUTHERLAND			4. DATE OF DEATH (Month) (Day) (Year) MAY-11-1949			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED L	8. DATE OF BIRTH Oct. 23-1864	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 6 Days 15	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.F.		10b. KIND OF BUSINESS OR INDUSTRY H	11. BIRTHPLACE (State or foreign country) Howard Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Jacob Keyser		13b. MOTHER'S MAIDEN NAME Virginia Ann Chandler		14. NAME OF HUSBAND OR WIFE EUGENE SUTHERLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) L		16. SOCIAL SECURITY NO. L		17. INFORMANT'S SIGNATURE OR NAME Mrs Fred Hodge Morris - Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paraplegia - Left Side		INTERVAL BETWEEN ONSET AND DEATH May 7-49
	ANTECEDENT CAUSES. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 7, 1949**, to **May 11, 1949**, that I last saw the deceased alive on **May 11, 1949**, and that death occurred at **20** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. P. Grotter M.D.	23b. ADDRESS Sturgeon Mo	23c. DATE SIGNED May 13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY-11-1949	24c. NAME OF CEMETERY OR CREMATORY HAYETTE CEM.	24d. LOCATION (City, town, or county) (State) HAYETTE - MO
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DATE REC'D BY LOCAL REG. May 16/1949	REGISTRAR'S SIGNATURE Maud M. Brink	25. FUNERAL DIRECTOR'S SIGNATURE Barnes & Boothe - Sturgeon - Mo.	ADDRESS Sturgeon - Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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0
0

FEB 15 1949

RECEIVED
District Health Officer No. 9
District File Number
Date Filed MAY 23 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

C. E. Boothe

Licensed Embalmer No. 4087

P. O. Address Sturgeon - 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.