

FILED FEB 5 1951

STANDARD CERTIFICATE OF DEATH

State File No. 668

290

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

BIRTH NO. 1-255 REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5344 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Aldrich R-1 Morgan</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Aldrich R-1 Morgan</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Aldrich R-1 Morgan</u>		d. STREET ADDRESS (If rural, give location) <u>Aldrich R-1 Morgan</u>	
3. NAME OF DECEASED a. (First) <u>Calvin</u> b. (Middle) <u>Everett</u> c. (Last) <u>Sunderland</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 9 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 10 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Joseph Sunderland</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Ann (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Etta Sunderland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several weeks</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>age -</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) <u>Dade Mo</u>	
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 <u>Jan 9, 1951</u> , to <u>Jan 6, 1951</u> , that I last saw the deceased alive on <u>Jan 6, 1951</u> , and that death occurred at <u>6 a.</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>B B Kirby MD</u> (Degree or title)		23b. ADDRESS <u>Dadaville Mo</u>	
23c. DATE SIGNED <u>Jan 19 51</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	
24b. DATE <u>Jan 10, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bona Cemetery Bona Mo</u>	
24d. LOCATION (City, town, or county) (State) <u>Bona Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Crum</u>	
DATE REC'D BY LOCAL REG <u>1-25-51</u>		REGISTRAR'S SIGNATURE <u>Geo L. Weir</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Crum</u>		ADDRESS <u>Dadaville, Mo</u>	

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED JAN 29 1951

Dist. File 151-246

Date Filed 1-29-51

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*William B. Erwin*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3092

P. O. Address Balmain, 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.