

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008469  
STATE FILE NUMBER

FILED FEB 25 1958

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Saline Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Miami Rural</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <u>4 mo.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Marie</u> Last <u>Sullivan</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1958</u>
5. SEX <u>Wh Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1902</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wif</u>		9b. AGE (In years last birthday) <u>5-5-</u>	9c. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wif</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Arrow Rock Mo</u>
13. FATHER'S NAME <u>John Moore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Luther Toliver Slater Mo</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Brain</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 5 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>195-3</u> to <u>2-21-1958</u> and last saw her <u>him</u> alive on <u>2-21-1958</u> Death occurred at <u>10:30</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Sullivan M.D.</u>		22b. ADDRESS <u>Miami, Mo.</u>	22c. DATE SIGNED <u>2-22-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-23-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Suggs Memorial Garden</u> <u>Slater City</u>	23d. LOCATION (City, town, or county) (State) <u>Marshall, Mo.</u>
24. FUNERAL DIRECTOR <u>Hill Bros. Slater</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Feb. 22 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Earl C. Metz</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify.

MAR 5 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by me....., Student ~~Embalmer~~ No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Sam M Hill.....

Licensed Embalmer No. 12

P. O. Address State

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed; fact should be so stated above.