

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

50M-9-19-38 I X16605

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

38995
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 1
 (b) Township _____ Primary Registration District No. _____
 (c) City St. Joseph Mo. (d) Street No. State Hospital #2 St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 1 yrs. 3 mos. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm. Sullivan
 (a) Residence, No. State Hospital #2 St. Kansas City Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED divorced
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nora Sullivan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 24 1891

7. AGE YEARS 48 MONTHS 5 DAYS 8
 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. comm. laborer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER
 13. NAME Dennis Sullivan
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
 15. MAIDEN NAME ?
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Mrs. Nora Flynn, R.C. Mo.
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Rt. Mo. DATE 11/29 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. J. Quinn, Kansas City Mo.

20. FILED 11/29 1939 W. J. Quinn
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 1 1939

22. I HEREBY CERTIFY, That I attended deceased from 10/25 1938 to 11/1 1939
 I last saw him alive on 11/1 1939 Death is said to have occurred on the date stated above, at 5:40 P.M.
 The principal cause of death and related causes of importance were as follows:
Arteriosclerosis Date of onset ?
97
 Other contributory causes of importance:
sclerotic degeneration of left heart July 1/39

Name of operation none Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) W. J. Quinn M. D.
85 (Address) St. Joseph Mo.

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 *Maurice M. Quinn*

Licensed Embalmer No. *2226*

P. O. Address.....

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, above space should be left blank.