

FILE JUN 10 1940

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

18040
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
(b) Township 2 Primary Registration District No. 3008 Registered No. 130
(c) City Fulton or (d) Street No. _____
(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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Michael J. Sullivan

(a) Residence, No. No State Protection Jefferson City (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 (write the word) DK

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF D. 19

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) D. 19

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 74?

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Prisoner
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) D.K. 9

FATHER 13. NAME D.K.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K. 9

MOTHER 15. MAIDEN NAME D.K.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.K. 9

17. INFORMANT (ADDRESS) State Hospital Record Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Columbia Mo. DATE 5-8, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. O. Roberts Columbia Mo.

20. FILED 5-8, 1940 R. N. Crewe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1940, to May 6, 1940
I last saw him alive on May 6, 1940 Death is said to have occurred on the date stated above, at 10:30 A.M.

The principal cause of death and related causes of importance were as follows:

Coronary occlusion
13C

Other contributory causes of importance: Chronic myocarditis

Name of operation _____ 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? _____
If so, specify _____
(Signed) R. N. Crewe, M. D.
(Address) Fulton Mo.

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

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.

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.