S. No. 2
—11-10-39
v. 5-17-39
I X21

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 17 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43027

Registration District No. 464 | Primary Registration District No. 5627 | Registrar's No. 49

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

1. PLACE OF DEATH:

(a) County: Lafayette

(b) City or town: Rural - Sni-bar (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6 mi. South West. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 65 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lafayette

(c) City or town: Rural - Sni-bar. (If outside city or town limits write "RURAL")

(d) Street No.: 6 mi. South West - Odessa (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: George Sullivan

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married.

6. (b) Name of husband or wife: Pearle Sullivan

6. (c) Age of husband or wife if alive: 59 years

7. Birth date of deceased: Jan (Month) 22 (Day) 1865 (Year)

8. AGE: Years 75 | Months 10 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: Near Lexington (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Farmer.

11. Industry or business: ____

FATHER
12. Name: Michael Sullivan
13. Birthplace: Ireland. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary Driland
15. Birthplace: Ireland. (City, town, or county) (State or foreign country)

16. (a) Informant: Amy C. Wyckoff
(b) Address: Grandview Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12 22-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Concord

18. (a) Signature of funeral director: Blanche Lane
(b) Address: Odessa Mo.

19. (a) 12-22-40 (Date received local registrar) (b) Mrs. E. M. Gordwin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 21 year 1940 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11-15, 1940, to 12-19, 1940 that I last saw him alive on 12-19-, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Edema — Duration

Due to: aortic aneurism

Due to: Chronic Myocardial disease

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: 96

Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Vern G. Snider (M. D. or other) DO

Address: Kansas City, Mo. Date signed: 12-21-40

(Licensed Embalmer's Statement on Reverse Side)

JUN 26 1945

RECEIVED
District Health Officer No. 8,
District File Number 1-7-41
Date Filed

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 [signature]

Licensed Embalmer No. 2945

P. O. Address Odessa 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, above space should be left blank.