

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FEB 18 1941

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH: **Jackson**
(a) County **Kansas City**
(b) City or town _____
(c) Name of hospital or institution **1109 East Armour Blvd**
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 YEARS**
In this community **9 YEARS**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **JOHN ALOYIUS SULLIVAN**
(b) If veteran, name war _____
(c) Social Security No. **083-07-5488**

4. Sex **Male**
5. Race **White**
6. (a) Single, widowed, married, divorced **Divorced**
(b) Name of husband or wife **Gladys Sullivan**
(c) Age of husband or wife if alive **46** years
7. Birth date of deceased **October 1 1882**
(Month) (Day) (Year)

8. AGE: Years **58** Months **3** Days **27**
If less than one day _____ hr. _____ min.

9. Birthplace **Staten New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **Carpet Company**

MOTHER FATHER { 12. Name **John Sullivan**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Campion**
15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward James Sullivan**
(b) Address **1109 East Armour Blvd**

17. (a) **Burial** (b) Date thereof **Jan 30 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **J. J. O'Donnell**
(b) Address **Kansas City Missouri**

19. (a) **Jan 29 1941** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
Kansas City
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. **1109 East Armour Blvd.**
(If rural, give location)
(e) If foreign born, how long in U. S. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month **Jan** Day **28** Year **1941** Hour **4** Minute **40** A. M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Acute Pulmonary Edema
Due to **Hypertensive Myocarditis**
Due to **Sclerotic Atherosclerosis**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 (a) Means of injury _____
23. Signature **J. J. O'Donnell** (M. D. or other) _____
Address _____ Date signed _____

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

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

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.