

Registration District No. 821Primary Registration District No. 6070

Registrar's No.

1. PLACE OF DEATH:

- (a) County Scott Mo.
 (b) City or town Sikeston, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution none
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution none
 (Specify whether years, months or days) 45 yrs.

3. (a) PRINT FULL NAME

JONAS. M. Sullivan

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex M5. Color or race W6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

7. Birth date of deceased

April 28 1864
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

7685

hr. min.

9. Birthplace

Carmi, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER

FATHER

12. Name

Unknown

13. Birthplace

Unknown
(City, town, or county) (State or foreign country)

14. Maiden name

Unknown

15. Birthplace

Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant

Monroe Sullivan

(b) Address

Sikeston, Mo.17. (a) Rural
(Burial, cremation, or removal)

(b) Date thereof

Jan 5, 41
(Month) (Day) (Year)

(c) Place: burial or cremation

McMullen, Mo.

18. (a) Signature of funeral director

Edwin Ekins

(b) Address

Sikeston, Mo.19. (a) 2-3-1941
(Date received local registrar)

(b)

[Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Scott
 (c) City or town Sikeston, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13
year 1941 hour 8:15 minute P M.21. I hereby certify that I attended the deceased for one year, 1940, to 1941, 1940;
that I last saw him alive on December 26, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death

Heart Block

Duration

Due to

Due to

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

Major findings:

Of operations

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?
at home

While at work?

(Specify type of place)

(e) Means of injury fall

23. Signature

[Signature] (M. D. or other) D.O.

Address

Sikeston, MissouriDate signed 1/24/41

15a

RECEIVED

District Health Officer No. 2,

District File Number 241-217

Date Filed 2/11/41

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.....

Travis Shelly

Licensed Embalmer No. 2726

P. O. Address East Prussia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4529

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 821

Primary Registration District No. 6070

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Richland
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Jonas M. Sullivan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 5

If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that his usual h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Block

Due to Myocarditis, Chronic 5 yrs.

Due to _____

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

Major findings: _____

Of operations _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]

Address Bellevue, Mo. Date signed 4/1/47

SUPPLEMENTARY

