DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6126

MAR 20 1941

Registration District No. 19 | Primary Registration District No. 4013 | Registrar's No.

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.

1. PLACE OF DEATH:

(a) County Atchison

(b) City or town Rock Port Mo.
(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 years, months or days)

In this community Most of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison 3

(c) City or town Rockport 1
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ROSS PAUL SULLIVAN.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Jennie Taylor

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July (Month) 10 (Day) 1880 (Year)

8. AGE: Years 60 | Months 7 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Barnville / Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation decorator

11. Industry or business

FATHER
12. Name George R. Sullivan
13. Birthplace Barnville / Ohio
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Harriett English
15. Birthplace Barnville / Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Geo. D. Sullivan

(b) Address Shenandoah Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Greenhill

18. (a) Signature of funeral director V. B. Bertram

(b) Address Rock Port Mo.

19. (a) Mar. 5-1941 (Date received local registrar) (b) Mary G. Chamberlain (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day fourth year 1941 hour 1:38 minute P. M.

21. I hereby certify that I attended the deceased from February 26, 1941, to March 4, 1941; that I last saw him alive on March 4th, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardio-renal affection	
Due to	
Due to	
Other conditions Chronic gastro-intestinal affection (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Wm R. Strickland (M. D. or other) M.D.

Address Rockport, Missouri Date signed 3-5-41

(Licensed Embalmer's Statement on Reverse Side)

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 By me, Registered Apprentice No. _____ working under my personal supervision.

Signed J. B. Bertram

Licensed Embalmer No. 4024

P. O. Address Rock Port Mo.

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

If this body is not embalmed, above space should be left blank.