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M-9-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20633

State File No.

Registrar's No. **2682**

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
4541 Chestnut
(If not in hospital or institution, write street number or location)

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

In this community 49 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 4541 Chestnut
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME JAMES F. SULLIVAN

3. (b) If veteran, name war No

3. (c) Social Security No. 490-16-0060A

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12th year 1943 hour..... minute..... M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Laura Jane Sullivan

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Sept 27 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1925 19..... to June 12 19.....

that I last saw him alive on June 5, 1943 19..... and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>8</u>	<u>15</u>hr.....min.

Immediate cause of death..... horary occlusion

Due to Diabetes

Due to hypertension

Due to arteriosclerosis

Other conditions fracture of neck of femur 6 mos ago
(Include pregnancy within 3 months of death)

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

10. Usual occupation Linotype Operator

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

11. Industry or business K. G. Star

12. Name J. H. Sullivan

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Coffey

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

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)

(h) Means of injury.....

23. Signature Flora Williams (M. D. or other)
Address 809 P. of Blvd Date signed 4/4/43

16. (a) Informant Mrs Laura Jane Sullivan

(b) Address 4541 Chestnut

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 6/15 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director W. E. Brown

(b) Address 20 West Linnwood

19. (a) 6-14-43 (Date received local registrar)

(b) W. E. Brown (Registrar's signature)

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 *Charles M. Zurb*
Licensed Embalmer No. *3774*
P. O. Address *Q. O. Me.*

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, fact should be so stated above.