

FILED JUL 3 1945
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2655

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:
3118 Michigan Avenue
(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 50 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. 3118 Michigan Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Mary SULLIVAN

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 21 st
year 1945 hour 5:15 minute P.M.

21. I hereby certify that I attended the deceased from Jan 26
1945 to June 18 1945
that I last saw him alive on June 18 1945
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Michael J. Sullivan 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased April 24th, 1869.
(Month) (Day) (Year)

Immediate cause of death Cerebral thrombosis. Duration
6-18-45

8. AGE: Years 76 Months 1 Days 27 If less than one day hr. min.

Due to hypertensive and cardiac vascular disease

Due to several years

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations C 93d

Of autopsy C

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

11. Industry or business At Home

12. Name Patrick Hayes

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

14. Maiden name Isabelle Naugher

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

16. (a) Informant Michael J. Sullivan, Husband

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

(b) Address 3118 Michigan, K.C. Mo.

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

17. (a) Burial (b) Date thereof 6-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence C

(c) Place: burial or cremation St. Marys Cemetery

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

18. (a) Signature of funeral director Melody-McGilley-Eyler

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

(b) Address 1800 Linwood, K.C. Mo.

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

19. (a) 6-22-45 (b) Geraldine Helmer
(Date received local registrar) (Registrar's signature)

23. Signature Geraldine Helmer (M. D. of center) C

Address 1-37 Prof. Kelly Date signed 6-22-45

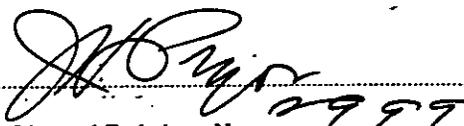
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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, fact should be so stated above.