. S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

29310

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 16 1948

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 30482

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3800

**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: St Lukes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 3 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Jackson
(c) City or town Lees Summit
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Roger Sullivan
3. (b) If veteran, name war —no
3. (c) Social Security No. none
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept 24, 1939 (Month) (Day) (Year)

8. AGE: Years 6 Months 11 Days 10 If less than one day hr. min.
9. Birthplace Joplin (City, town, or county) Mo (State or foreign country)
10. Usual occupation Child.
11. Industry or business
MOTHER FATHER
12. Name Walter Sullivan
13. Birthplace Maryville (City, town, or county) Mo (State or foreign country)
14. Maiden name Nity Hempston
15. Birthplace Cabra (City, town, or county) Mo (State or foreign country)
16. (a) Informant Frank Atkins
(b) Address 606½ main Joplin Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-5-46 (Month) (Day) (Year)
(c) Place: burial or cremation Joplin Mo
18. (a) Signature of funeral director Blackman
(b) Address K C Mo
19. (a) 9-4-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 4 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from 31 Aug. ~~Sept~~ 1946 to 4 Sept 1946 that I last saw him alive on 4 Sept. 1946 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Tracheal obstruction | 12 hrs. |
| Due to: Acute Polio Myelitis Bulbar | 7 days |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: 36 | |
| Of autopsy Tracheal obstruction | |

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 0
23. Signature Ann C Jones Jr. (M. D. or other)
Address 9 W 85 St. Kansas City, Mo. Date signed 4 Sept 1946

(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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed H D Blackman

Licensed Embalmer No. 3639

P. O. Address K C Mo

**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.**