

S. No. 2
M-5-43
7. 5-17-39
D I X36671

FILED JUN 9 1947

Registration District No. 189

Primary Registration District No. 1002

Registrar's No. 2361

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. Joseph Hosp. 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4-25-47 5-26-47
(Specify whether years, months or days)
 In this community 65 Years

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. 3418 Washington
(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. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 26th day May
 year 1947 hour 11:35 minute 0 M.
 21. I hereby certify that I attended the deceased from April 10th 1947 to May 26th 1947
 that I last saw her alive on May 17th 1947
 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 Widowed
 6. (b) Name of husband or wife Nickolas Sullivan
 6. (c) Age of husband or wife if alive 10 years
 7. Birth date of deceased May 10 1865
(Month) (Day) (Year)

Immediate cause of death Hypertensive heart disease
atrial fibrillation
 Due to Hypertension
 Due to _____

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>0</u>	<u>16</u>	hr. min.

Other conditions 93-2
 * (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace Ireland
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

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)
 (b) Means of injury _____

11. Industry or business _____
 12. Name Thomas Comiskey
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Mary McMannus
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Teresa Comiskey
 (b) Address 3810 Flora
 17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 5-29-47
(Month) (Day) (Year)
 (c) Place: burial or cremation St. Marys Cemetery

23. Signature James P. Smith (M.D. or other)
 Address 318 Professional Bldg Date signed 5/29/47
AL. No.

18. (a) Signature of funeral director Arthur J. Johnson
 (b) Address 20 W. Linwood
 19. (a) 5-29-47 (b) Gertrudine Holme
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 Harold W. Farnell.....

Licensed Embalmer No. 4134.....

P. O. Address Kansas City, 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.