

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:
Menorah Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 30 years

3. (a) PRINT FULL NAME Michael J. SULLIVAN

3. (b) If veteran, name war no

3. (c) Social Security No. 491-20-9499

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Clara Turner

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

7. Birth date of deceased June 15, 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>10</u>	<u>20</u>	hr. min.

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

10. Usual occupation Oil Producer

11. Industry or business Kansas City, Mo.

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mr. Thomas E. Sullivan

(b) Address 615 E. 72d St., K.C., Mo.

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

(b) Date thereof 5-6-48
(Month) (Day) (Year)

(c) Place: burial or cremation Lima, Ohio

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

(b) Address Kansas City, Missouri

19. (a) 5-6-48
(Date received local registrar)

(b) Geraldine Holmes
(Registrar's signature)

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. Bellerive Hotel
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1948 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 30-5-5 to 5-5-5 and that death occurred on the date and hour stated above.

Immediate cause of death Acute glomerulonephritis

Other conditions Coronary Insufficiency
Hypertension

Major findings:
Of operations _____

Of autopsy 1318

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? _____

While at work? _____

23. Signature M. Black
Address 15 E. 7th

Date signed 7/6/48

*Dr. W. R. Black
Research Hosp.*

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. *2999*
P. O. Address..... *CC*

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.