

FILED SEP 18 1948
Registration District No. _____

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: St Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 minutes
In this community life
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Timothy Sullivan
(b) If veteran, name war no
(c) Social Security No. none

4. Sex M Color or race W
5. (a) Single, widowed, married, divorced single
(b) Name of husband or wife _____
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 23 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 12
If less than one day hr. _____ min.

9. Birthplace Kansas City, Ks
(City, town, or county) (State or foreign country)
10. Usual occupation child

11. Industry or business _____
12. Name Wm. Sullivan
13. Birthplace Trinidad Colorado
(City, town, or county) (State or foreign country)
14. Maiden name Anna Stephenson
15. Birthplace Hooker Okla
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Sullivan
(b) Address 4115 Shawnee Road
17. (a) Res. (b) Date thereof 9-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Luke's Hosp
18. (a) Signature of funeral director S. J. J. J.
(b) Address K.C.K.
19. (a) 9-6-48 (b) S. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Wy
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4115 Shawnee Rd
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 4
year 1948 hour 17 minute 20 P.M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Due to Lateral Sinus Thrombosis
Due to Congenital Heart Disease
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy aut.
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? _____ (Specify type of place) (b) Means of injury _____
23. Signature J. C. N. J. J. (M. D. or other) _____
Address St. Luke's Hospital Date signed Sept 10, 1948

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. 3903

working under my personal supervision.

Signed.....

H. Linnova

Licensed Embalmer No. 3903

P. O. Address. K C K

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.