

FILED NOV 2 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 34059

34059

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 352

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Lee</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Brookfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FT. Madison</u> <u>8140</u>	
c. LENGTH OF STAY (in this place) <u>2 mo.</u>		d. STREET ADDRESS (If rural, give location) <u>502-8th Street.</u> <u>8</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Collins Nursing Home</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John Patrick</u> b. (Middle) <u>Patrick</u> c. (Last) <u>Sullivan</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct, 13, 1950</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 10, 1869</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR <u>10</u> Months	IF UNDER 12 HRS. <u>3</u> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Schuyler Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>John P Sullivan</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Hickey</u>	14. NAME OF HUSBAND OR WIFE <u>Mary A Sullivan deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J H Sullivan Ft. Madison Iowa</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> <u>with TBC</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis, moderate heart disease & Decomposition</u> II. OTHER SIGNIFICANT CONDITIONS :- Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-1</u> , 19 <u>50</u> to <u>10-12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>50</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Robert W. Smith M.D.</u> (Degree or title)		23b. ADDRESS <u>Marceline Mo.</u>	23c. DATE SIGNED <u>10-13-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>Oct. 16 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	24d. LOCATION (City, town, or county) (State) <u>Fort Madison Iowa</u>
DATE REC'D BY LOCAL REG. <u>10-21-50</u>	REGISTRAR'S SIGNATURE <u>H. B. Erwin</u> <u>1670</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James M. Laughlin Marceline Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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Date Received: **OCT 30 1950**
DISTRICT HEALTH OFFICE #2
District File Number 10-50-1782
Date Filed: **OCT 31 1950**

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Francis L. Schaberg

Licensed Embalmer No. 4513

P. O. Address Marceline 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.