

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1456

STATE FILE NUMBER

166

FILED FEB 3 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 166

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION N.E. Osteopathic			Length of stay in hospital 10 yrs.		d. STREET ADDRESS 3621 Garner		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLADYS Middle MABLE Last SULLIVAN				4. DATE OF DEATH Month 1 Day 8 Year 1958				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1902		9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) Webb City, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Asahel Nichols				14. MOTHER'S MAIDEN NAME Ora Keen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No X X X X X			16. SOCIAL SECURITY NO. 486 10 8909		17. INFORMANT Mr. J. Clyde Sullivan			Address 3621 Garner
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) ARTERIO SCLEROSIS					DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from 12/4/57 to 1/8/58 and last saw her alive on 1/8/58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE J. Rosen D.O. (Degree or title) 2				22b. ADDRESS 576 12th Walnut Pl. S.E.		22c. DATE SIGNED 1/10/58		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-11-1958	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) Kansas City		STATE Missouri	
24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapels, Inc K.C. Mo				25. DATE RECD. BY LOCAL REG. 1-11-58		26. REGISTRAR'S SIGNATURE Neva Marshall		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. Rosen

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
Signature of Student Embalmer

Signed *[Handwritten Signature]*
Licensed Embalmer No.

P. O. Address *[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

12531226
Dr. Room
6600 East
at 11:00 AM
1111 W. 72
119 Van Buren
Dr. 1-0162