

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017971

State File No.

FILED JUN 9 1959

BIRTH NO. 6 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2411

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, write RURAL and give town) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 3617 Tracy	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Christopher b. (Middle) Sullivan c. (Last) Sullivan			4. DATE OF DEATH (Month) (Day) (Year) May 13, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Newborn	8. DATE OF BIRTH May 13, 1959	9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months 1 Days 15 IF UNDER 4 HRS. Hours 1 Min. 15
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn	10b. KIND OF BUSINESS OR INDUSTRY Newborn	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME James Robert Sullivan	13b. MOTHER'S MAIDEN NAME Bonnie Jo Wigham	14. NAME OF HUSBAND OR WIFE Newborn
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME James Robert Sullivan ADDRESS -3617 Tracy
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stale status		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Inflammation 27 weeks		
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-13, 1959, to 5-13, 1959, that I last saw the deceased alive on 5-13, 1959, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Richard H. Helmer (Degree or title)	23b. ADDRESS 675 Oak Bldg	23c. DATE SIGNED 5-14-59
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE May 14, 1959	24c. NAME OF CEMETERY OR CREMATORY Mound Grove Cemetery	24d. LOCATION (City, town, or county) (State) Independence, Mo.
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DATE REC'D BY LOCAL REG. 5-14-59	REGISTRAR'S SIGNATURE new munsell	25. FUNERAL DIRECTOR'S SIGNATURE Geo. C. Carson & Sons ADDRESS Independence, Mo.
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Richard H. Helmer

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 _____

Not embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Raymond F. Hoem*

Licensed Embalmer No. *4266*

P. O. Address *Independence*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.