

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 18 1959 78

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59-035017

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Wright</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mountain Grove</b>		Length of stay in lb <b>47 yrs</b>		c. CITY OR TOWN <b>Mountain Grove</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>530 West North Street</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>530 West North Street</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>R.</b> Last <b>Sullivan</b>				4. DATE OF DEATH Month <b>September</b> Day <b>4,</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/13/1918</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-Build. Contractor</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Vinyard, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Jacob Sullivan</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Weeten</b>			14. NAME OF HUSBAND OR WIFE <b>Laura Duvall Sullivan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Bouldin Sullivan Mtn. Grove, Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. Month, Day, Year _____	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 <b>2-7-57</b> to <b>9-3-59</b> and last saw <sup>her</sup> him alive on <b>9-3-59</b> Death occurred at <b>7:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>W. A. Craig D.O.</b> (Degree or title)				22b. ADDRESS <b>Mountain Grove Mo</b>		22c. DATE SIGNED <b>9-9-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/6/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION (City, town, or county) <b>Mountain Grove, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Barber Funeral Home Mtn. Grove, Mo</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>9-10-1959</b>	26. REGISTRAR'S SIGNATURE <b>Bernice L. Silverman</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Date Filed Sept 14, 31

**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 George Stapp

Licensed Embalmer No. 3101

P. O. Address W. Bauer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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