

Dr. Roller
RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 8 1960

-60-031358

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 356

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion			
b. CITY (If outside corporate limits, give TOWNSHIP only) Hannibal			Length of stay in 1b		c. CITY OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1633 Broadway		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leo W. Middle Sullivan Last				4. DATE OF DEATH Month 8 Day 25 Year 1960			
5. SEX Male	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 3/13/1905	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY Intern'l Shoe Co.		11. BIRTHPLACE (City and state or country) Monroe City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John P. Sullivan			13b. MOTHER'S MAIDEN NAME Anna Grimm		14. NAME OF HUSBAND OR WIFE Juanita Sullivan		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 490-07-5086		17. INFORMANT Mrs. Juanita Sullivan Address 1633 Broadway, Hannibal, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion							INTERVAL BETWEEN ONSET AND DEATH half hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
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		
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 Month, Day, Year 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 1/8/60 to 8/25/60 and last saw her/him alive on 8/16/60 Death occurred at 10:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) M. J. Roller, M.D.			22b. ADDRESS 2910 St. Marys Avenue, Hannibal, Mo.			22c. DATE SIGNED 8/29/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/27/1960	23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park Hannibal, Mo.		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR H. M. O'Donnell, Hannibal, Mo.			25. DATE RECD. BY LOCAL REG. 9/6/60		26. REGISTRAR'S SIGNATURE Dr. E. M. Locke by William M. Norman		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Clyde C. Wesley*

Licensed Embalmer No. 3820

P. O. Address *Perry, Ind*

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.