

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002257

STATE FILE NUMBER

FILED VS JAN 24 1961

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 13

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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) OR TOWN Hannibal			Length of stay in 1b		c. CITY OR TOWN Hannibal		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1603 Grace St.,		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Clyve Middle B. Last Sullivan						4. DATE OF DEATH Month 1/9/1961 Day 9 Year 1961							
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 4/24/1897		9. AGE (last birthday) 63		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Hannibal, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Peter B. Sullivan				13b. MOTHER'S MAIDEN NAME Mollie Fount Rose				14. NAME OF HUSBAND OR WIFE Anna May Simon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Anna M. Sullivan							
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 vascular accident								INTERVAL BETWEEN ONSET AND DEATH 1 day					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Recurrent duodenal ulcer					?					
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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>				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 12/29/60 to 1/9/61 and last saw her/him alive on 1/8/61				Death occurred at 5:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) J. W. Watschenberg M.D.						22b. ADDRESS 1209 Broadway, Hannibal, Mo.				22c. DATE SIGNED 1/10/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/11/1961		23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park, Hannibal, Mo.				23d. LOCATION (City, town, or county) Hannibal, Mo.		(State)			
24. FUNERAL DIRECTOR H.M.O'Donnell, Hannibal, Mo.				25. DATE RECD. BY LOCAL REG. 11/11/61		26. REGISTRAR'S SIGNATURE Dr. E.M. Rucke by Lillian M. Gorman							

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 W. M. O'Donnell

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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