

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-045086**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

FILED JAN 8 1967 <sup>149</sup> Primary Registration District No. 1002 Registrar's No. 6477

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Kansas City</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>Trinity Lutheran Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2632 Summit</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Sullivan</b> Last <b>Sullivan</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Female</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>10-6-74</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Timothy Scanlon</b>		13b. MOTHER'S MAIDEN NAME <b>Honorah Eagan</b>		14. NAME OF HUSBAND OR WIFE <b>John J. 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.. <b>None</b>		17. INFORMANT Address <b>John S. Sullivan, 800 W. 68th Terr. K.C. Mo</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>Acute Cerebral Hemorrhage</b> DUE TO (b) <b>Cerebral Arteriosclerosis 5 yrs</b> DUE TO (c) <b>Generalized Arteriosclerosis 5 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>personal neck fracture left</b> 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	
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.) <b>Fell on steps</b>				
20c. TIME OF INJURY Hour <b>12:30</b> Month, Day, Year <b>Sept-27-61</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>		COUNTY <b>Jackson</b>	STATE <b>Mo</b>	
21. I attended the deceased from <b>Sept-27-61</b> to <b>Dec-25-61</b> and last saw her alive on <b>Dec-25-61</b> Death occurred at <b>12:30</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Carl H. Brust</b>		(Degree or title) <b>M.D.</b>		22b. ADDRESS <b>106 W. 14th St - K.C. Mo</b>	22c. DATE SIGNED <b>Dec-26-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-28-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>	
24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar, 20 W. Linwood</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>12-26-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

K.C. MO  
I received Emballer's Statement on Reverse Side)

Mr. Burt  
Pr. Higgins  
Bldg

**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 Wayd F. Dickmon

Licensed Embalmer No. 5120

P. O. Address K.E. 9, m

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.