

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**62-006931**

STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 41

AMENDED

**FILED MAR 5 1962**

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Crawford</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webb City</b>		c. CITY OR TOWN <b>Pittsburg</b>	
Length of stay in 1b <b>1 Day</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jane Chinn Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>RFD # 3</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JOHN ARTHUR</b> Middle <b>SULLIVAN</b> Last			4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1962</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 type="checkbox"/> Divorced <input type="checkbox"/> <b>Infant</b>	8. DATE OF BIRTH <b>1-23-62</b>	9. AGE (last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>1</b> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (City and state or country) <b>Webb City, MO.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Malen Sullivan</b>		13b. MOTHER'S MAIDEN NAME <b>Jane Hedges</b>	
14. NAME OF HUSBAND OR WIFE <b>None</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 <b>Malen Sullivan RFD 3 Pittsburg, KS</b>		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Auricular Fibrillation</b>		<b>8 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>interstitial Pneumonitis</b>	<b>2 Days</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
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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"/> a.m. <input type="checkbox"/> 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
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21. I attended the deceased from 2-23-62 to 2-23-62 and last saw her alive on 2-23-62  
Death occurred at 4:25 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Wm. Wells-Rogers</i> (Degree or title)	22b. ADDRESS <i>924 N. Dougherty, Webb City, Mo.</i>	22c. DATE SIGNED <i>2-26-62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/23/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crocker Cemetery</b>	23d. LOCATION (City, town, or county) <b>Cherokee Co., Kansas</b>
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24. FUNERAL DIRECTOR <b>E. K. Smith</b>	ADDRESS <b>Pittsburg, Kans.</b>	25. DATE RECD. BY LOCAL REG. <b>2-26-62</b>	26. REGISTRAR'S SIGNATURE <i>Mrs. Madeline Switzer</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

STATE OF MISSOURI

DEPARTMENT OF HEALTH

CERTIFICATE OF EMBALMING

THIS BODY WAS EMBALMED BY

NAME OF EMBALMER

ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_

AT \_\_\_\_\_

CITY OF \_\_\_\_\_

STATE OF MISSOURI

DEPARTMENT OF HEALTH

**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 Juanita Smith

Licensed Embalmer No. 3468

P. O. Address Atchison, Kansas

SA-30-5

SA-30-5

SA-30-5

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.