

FILED JUN 24 1943
Registration District No. 19

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital - 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days (Specify whether
In this community 23 yrs years, months or days)

3. (a) PRINT FULL NAME Albert Sullivan

3. (b) If veteran, name war yes 3. (c) Social Security No. 495-03-8927

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Dotty 6. (c) Age of husband or wife if 50 years

7. Birth date of deceased Dec 15 1880
(Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 13 If less than one day hr. min.

9. Birthplace Stillwater Minn
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Bookkeeper

11. Industry or business Pack Island R.R.

12. Name Terrence Sullivan

13. Birthplace Not known

14. Maiden name Bertha

15. Birthplace Not known

16. (a) Informant Mrs. Dotty Sullivan

(b) Address 2 St. M. Missouri

17. (a) Burial (b) Date thereof 6-1-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Quirk and Dolan Co.

(b) Address 20 W. Linwood

19. (a) 6-2-43 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2 West Missouri Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1943 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from May 9, 1943, to May 28, 1943;

that I last saw him alive on May 28, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchiectasis

Due to 106 B

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (a) Means of injury

23. Signature Dray R. Stone (M. D. or other) Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JUL 5 1958

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Charles M. Quirk*.....
Licensed Embalmer No..... *3774*.....
P. O. Address..... *K. C. 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 this body is not embalmed, fact should be so stated above.