

FILED APR 10 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1587

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 No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 19 days
 (Specify whether
 In this community 25 years
 years, months or days)

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. Studio Bldg.
 (If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country X

3. (a) PRINT FULL NAME Miss Jessie Sullivan
 3. (b) If veteran, name war no.
 3. (c) Social Security No. 49 6-09-0097

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 31
 year 1946 hour 6 minute 45 A.M.

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife X
 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased July 29 1872
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 12 1946 to March 31 1946;
 that I last saw her alive on March 31 1946;
 and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 8 Days 2
 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebrovascular accident
 Due to _____
 Due to _____

9. Birthplace Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Postal Clerk and Librarian

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: 83a
 Of operations _____

11. Industry or business X
 12. Name W. T. Sullivan
 13. Birthplace Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name Carrie Carter
 15. Birthplace Iowa
 (City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Of autopsy None

16. (a) Informant Frank Sullivan
 (b) Address 912 E. 25th, Kansas City, Mo.
 17. (a) removal (b) Date thereof 4-1-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Gallatin, Missouri

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) (e) Means of injury 0

18. (a) Signature of funeral director Stine & McClure
 (b) Address 3235 Gillham Plaza, K. C., Mo.
 19. (a) 4-2-46 (b) Theraldine Holmes
 (Date received local registrar) (Registrar's signature)

23. Signature Wm W. Hart (M. D. or other) md
 Address Med. Dir. Gen'l Hosp. Date signed 4-1-46

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

8644

A. Douglas

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: *[Signature]*

Licensed Embalmer No. *1415*

P. O. Address: *[Signature]*

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..