

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13146**  
**1797**

**MAY 3-1952**

BIRTH NO. **21920** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	c. LENGTH OF STAY (in this place) <b>9 days 11 hrs 20 min</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		d. STREET ADDRESS (If rural, give location) <b>3036 E. 32nd St</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Elizabeth Ann</b> b. (Middle) <b>Sullivan</b> c. (Last) <b>Sullivan</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>4-20-52</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>( )</b>	8. DATE OF BIRTH <b>4-11-52</b>	9. AGE (In years last birthday) <b>9</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b> Min. <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Thomas Jacob Sullivan</b>	13b. MOTHER'S MAIDEN NAME <b>Theresa Wilma Heflin</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'S SIGNATURE OR NAME <b>Mrs. Thomas Sullivan</b>
		ADDRESS <b>3036 E. 32nd St.</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>9 days</b> <b>751X</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* a. <b>Congenital hydrocephalus and</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Spina bifida with meningo-</b> DUE TO (c) <b>myelocoele</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Bilateral pes varus</b>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 11, 1952** to **April 20, 1952**, that I last saw the deceased alive on **April 20, 1952**, and that death occurred at **6:30** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Angelo Lap</b> (Degree or title) <b>Angelo Lap M.D. Anesthesiologist</b>		23b. ADDRESS <b>101 Memorial Drive</b>	23c. DATE SIGNED <b>4/20/52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>4-21-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Columbia Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Conception MO</b>
DATE REC'D BY LOCAL REG. <b>4-20-52</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Holmes</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Willie's Funeral Home 12 E. MO</b>	

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>was</sup> ~~was~~ embalmed by me, or by \_\_\_\_\_

*Not*

*Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Chas E Wilks*

Licensed Embalmer No. *2644*

P. O. Address *He 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.