

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27744**
3411

FILED AUG 18 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSASCITY	c. LENGTH OF STAY (In this place) 30 yrs	c. CITY OR TOWN KANSASCITY	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST MARYS HOSPITAL		e. STREET ADDRESS (If rural, give location) 4007 PROSPECT	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) E. c. (Last) Sullivan			4. DATE OF DEATH (Month) (Day) (Year) JULY 15 1954		
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH DEC 24, 1876	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Locustgap, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
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13a. FATHER'S NAME STEPHEN HEFFRON		13b. MOTHER'S MAIDEN NAME JANE CANNON		14. NAME OF HUSBAND OR WIFE Albert Sullivan-Deceased	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Catherine Graham-4007 Prospect		ADDRESS 4007 Prospect	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Portal Vein Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dehydration + Electrolyte Imbalance				DUE TO (c) heat exhaustion	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				E931940	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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) 2 (STATE) 2	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Richard C. Schaffer M.D. <i>autopsy surgeon</i>		23b. ADDRESS St Mary's Hosp K.C., Mo.		23c. DATE SIGNED 7-15-54	
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE July 17 1954	24c. NAME OF CEMETERY OR CREMATORY St. Johns, K.C. Kans	24d. LOCATION (City, town, or county) (State) Kansas City, Kans		
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DATE REC'D BY LOCAL REG. 7-16-54	REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Quirk & Tobin-20 W. Linwood, K.C. Mo.		
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Richard C. Schaffer MD

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, ~~only~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Forest D. Caldwell*

Licensed Embalmer No. *4714*

P. O. Address *K. P. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.