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THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 8 - 1955

State File No. **21248**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **780**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) Unk.		e. STREET ADDRESS (If rural, give location) 708 No. 4th Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 708 No. 4th Street			

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) E. c. (Last) SULLIVAN	4. DATE OF DEATH (Month) (Day) (Year) July 28, 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Aug. 17, 1894	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lynotype Opr.	10b. KIND OF BUSINESS OR INDUSTRY Printing	11. BIRTHPLACE (City and State or Foreign Country) Algiers, La.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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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) Yes. W.W. # 1	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME American Red Cross	ADDRESS St. Joseph, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Hemorrhage		Interval between onset and death
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last... DUE TO (b) General Arteriosclerosis DUE TO (c) 331X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death... Man drank alcoholic liquor to excess (wine)			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION man died while alone in his shed in his room.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a.s., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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 **7/28, 1955** to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. F. Mundy (Coroner)	23b. ADDRESS St. Joseph, Mo.	23c. DATE SIGNED 7/28/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 29/55	24c. NAME OF CEMETERY OR CREMATORY Ft. Leavenworth Nat.	24d. LOCATION (City, town, or county) (State) Leavenworth, Kans.
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DATE REC'D BY LOCAL REG. Aug. 4, 1955	REGISTRAR'S SIGNATURE Cather M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Barry Funeral Home	ADDRESS St. Joseph
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 3 1955

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 *Bill J. Conway*.....

Licensed Embalmer No. *467*

P. O. Address *St. J. 75*

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.