

FILED FEB 3 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1457

STATE FILE NUMBER 131

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LUKES HOSPITAL 7 1/2 years			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 214 ARMOUR.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS SULLIVAN				4. DATE OF DEATH Month Day Year Jan. 8 1958					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1870		9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR, RETIRED			10b. KIND OF BUSINESS OR INDUSTRY ILL. CENT. R.R.		11. BIRTHPLACE (City and state or country) DE GRAFF, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME MICHAEL SULLIVAN			13b. MOTHER'S MAIDEN NAME HONORA MURPHY			14. NAME OF HUSBAND OR WIFE ELMA SULLIVAN			
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 Address ELMA SULLIVAN - 214 Armour				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> DUE TO (b) <u>Myocardial Ischemia</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia, Emphysema</u>							INTERVAL BETWEEN ONSET AND DEATH 4 1/2		
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>12-22-54</u> to <u>1-8-58</u> and last saw her alive on <u>1-7-58</u> Death occurred at <u>One A.M. on the date stated above; and to the best of my knowledge, from the causes stated.</u>									
22a. SIGNATURE (Degree or title) <u>Robert K. Skilling M.D.</u>				22b. ADDRESS <u>4635 Wyandotte, K.C. Mo.</u>			22c. DATE SIGNED <u>1-8-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 9-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cem</u>		23d. LOCATION (City, town, or county) <u>Hickman Mills Mo</u>		(State)		
24. FUNERAL DIRECTOR <u>Melody K. Kelly Embalmer</u> Address <u>RE, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-9-58</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshel</u>			

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms write by initials. All diseases in Part I must be causally related.

Robert K. Skilling

(Licensed Embalmer's Statement on Reverse Side)

Dr Phillip L Byers
4635 Wyandotte
JE-1-5663
in next 10 minutes
11: - 6PM. Thurs.



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 *James W. Wair*

Licensed Embalmer No. *4650*

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