

Dr. Walterscheid

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2027

STATE FILE NUMBER

FILED FEB 7 1958

 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 23

 Health,  
Welfare  
Public  
Service
300  
-57

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>804 Birch St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>B.</u> Last <u>Sullivan</u>			4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/12/1883</u>	9. AGE (In years last birthday) <u>74</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Monroe County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dennis Sullivan</u>		13b. MOTHER'S MAIDEN NAME <u>Laura O'Brien</u>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Julia Salyer, 804 Birch St.</u>			
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>Cerebral vascular accident</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>Hypertensive cardio vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute urinary retention</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 years</u> <u>5 years</u>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <u>12:50</u> Month <u>12</u> Day <u>7</u> Year <u>1958</u> a.m. <u>P.M.</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
20d. INJURY OCCURRED WHILE AT <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>12/7/58</u> to <u>1/27/58</u> and last saw her/him alive on <u>1/27/58</u> Death occurred at <u>12:50 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Dr. Walterscheid M.D.</u>			22b. ADDRESS <u>508 Broadway, Hannibal, Mo.</u>		22c. DATE SIGNED <u>1/29/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/29/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Palmyre, Missouri</u>		
24. FUNERAL DIRECTOR <u>H.M. O'Donnell, Hannibal, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-1958</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Buckley &amp; C. Fisher</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

FEB 5 1958

RECEIVED

MARION CO. HEALTH DEPT

DATE FILED

FEB 5 1958

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 ..... *A. M. McDonnell* .....

Licensed Embalmer No. 3889 .....

P. O. Address Hannibal, 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.