

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**9549-62-036768**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

<b>FILED OCT 1 1 1962</b>		1. PLACE OF DEATH a. COUNTY <b>Illinois</b> b. COUNTY <b>Christian</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST. LOUIS, MISSOURI</b>		Length of stay in lb	c. CITY OR TOWN <b>Ricks</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R. R.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARJORIE R. SULLIVAN</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 5 1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/1920</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (last birthday) <b>42</b> IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Morrisonville, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Schmedke</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Burkshire</b>	14. NAME OF HUSBAND OR WIFE <b>John Roy</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No. Nil.</b>		17. INFORMANT Address <b>John Roy Sullivan, Ricks, Illinois.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>RHEUMATIC HEART DISEASE</b> DUE TO (c) <b>4/6 x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>20 YEARS</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m. Month, Day, Year	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 <b>SEPT. 11, 1962</b> to <b>OCT. 5, 1962</b> and last saw her/him alive on <b>OCT. 5, 1962</b> Death occurred at <b>5:35 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>[Signature]</i> M. D.		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>10/5/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-5-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Morrisonville Cem.</b>	23d. LOCATION (City, town, or county) <b>Morrisonville, Ill.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 5 1962</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D.

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 Leonard Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.