

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019294  
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 168

**FILED JUN 3 1963**

DO NOT WRITE ON THIS STUB      AMENDED

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1 0147			
2 7005			
3			
4 0			
5 0			
6			
7 1			
8 2			
9 4201			
10			
11			
12 93-2			
13 1-0			
USE BLACK INK OR TYPEWRITER RIBBON	SHOULD READ	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>45 yrs.</u>	c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp #1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Sullivan</u> Last <u>Sullivan</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u> 9. AGE (last birthday) <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INmate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Institution</u>	11. BIRTHPLACE (City and state or country) <u>Massachusetts</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>State Hosp #1 Fulton, Mo.</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>Coronary occlusion</u> <u>Coronary thrombus</u> Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) <u>Coronary thrombus</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 <u>9:55</u> a.m. <u>9:55</u> 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>7-6-1918</u> to <u>5-25-1963</u> and last saw him alive on <u>5-25-63</u> Death occurred at <u>5-25-63</u> <u>9:55</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Neil H. Stinson, D.O.</u>		22b. ADDRESS <u>State Hosp #1 Fulton Mo.</u>	22c. DATE SIGNED <u>5-25-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5-28-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Robert D. Johnston Columbia Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 28-1963</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>

FILED IN 1912

not a

signature

1912  
-2007

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5-20

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P.O. Address \_\_\_\_\_

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.