

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042731
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 391

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 9 1963

1. PLACE OF DEATH
a. COUNTY Adair
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville Length of stay in 1b years
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim - Smith Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Adair
c. CITY OR TOWN Kirksville Inside Limits Yes No
d. STREET ADDRESS (if outside, give location) Reside on Farm Yes No
National Bank Apts.

3. NAME OF DECEASED (Type or print) First Middle Last
ANNA MYRTLE SULLIVAN
4. DATE OF DEATH Month Day Year
November 29 1963

5. SEX Female 6. COLOR OR RACE White 7. ~~Widowed~~ Never Married 8. DATE OF BIRTH 11/6/79 9. AGE (last birthday) 84
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY own Home 11. BIRTHPLACE (City and state or country) Adair County, Mo. 12. CITIZEN OF WHAT COUNTRY U S

13a. FATHER'S NAME John Mikel 13b. MOTHER'S MAIDEN NAME Missouri Edwards 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 serv) No No 17. INFORMANT J. C. Montgomery, Greenriver, Wyo. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metabolic acidosis
DUE TO (b) Insanition & Dehydration
DUE TO (c) Acute Cholecystitis & Cholelithiasis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Oral moniliasis
PART III. If deceased was female was there a pregnancy in last 90 days Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 11/16/63 to 11/29/63 and last saw her alive on 11/29/63
Death occurred at 6:50 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Albert G. ... 22b. ADDRESS Grim - Smith Hosp, Kirksville, Mo 22c. DATE SIGNED 12/2/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE Dec. 2/63 23c. NAME OF CEMETERY OR ~~factory~~ Union Temple 23d. LOCATION (City, town, or county) Adair County, Mo. (State)

24. FUNERAL DIRECTOR Foster Memorial Home, Kirksville, Mo. ADDRESS 25. DATE RECD. BY LOCAL REG. 12-3-1963 26. REGISTRAR'S SIGNATURE Drew W. Rath

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATE BY DR. Grant

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

No permit needed

ALBERT J. GRANT, M.D.

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 Norm B Foster

Licensed Embalmer No. 4742
P. O. Address Arkville, 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.