

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

65-030541
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 336 Primary Registration District No. 6132 Registrar's No. 284

FILED AUG 11 1965

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1 1010						
2 1010						
3						
4 0						
5 1						
6						
7 0						
8 0						
9 420.1						
10						
11						
12 90-0						
13 1-0						
ITEM NO.	SHOULD READ					

1. PLACE OF DEATH a. COUNTY Shannon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Shannon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moore Township		Length of stay in 1b Unk	c. CITY OR TOWN Moore Township Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home Moore Township		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Moore Township Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Golden Middle Ray Last Sullivan			4. DATE OF DEATH Month July Day 22 Year 1965
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 11-9-09
9. AGE (last birthday) 55		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of previous life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self employed	11. BIRTHPLACE (City and state or country) Reynolds County, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Jerome Sullivan	
13b. MOTHER'S MAIDEN NAME Delilah Patterson		14. NAME OF HUSBAND OR WIFE Alta 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. 490-14-3250	17. INFORMANT Address Alta Sullivan, Bunker, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion.			INTERVAL BETWEEN ONSET AND DEATH Hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Jan. 1958 to April 1964 and last saw xx him alive on April 1964 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <i>Mark M. [Signature]</i>		22b. ADDRESS Salem, Missouri	22c. DATE SIGNED 8/2/65
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-25-1965	23c. NAME OF CEMETERY OR CREMATORY Bunker Cemetery	23d. LOCATION (City, town, or county) (State) Bunker, Missouri
24. FUNERAL DIRECTOR Spencer Funeral Home, Salem, Mo.		25. DATE RECD. BY LOCAL REG. 7/28/65	26. REGISTRAR'S SIGNATURE <i>Mabel [Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

AUG 12 1965

Robert A. York

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 *Robert A. York*

Licensed Embalmer No. 5193

P. O. Address *Salem, 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.