WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St. Louis, Mo. (No. Bethesda Hospital St.: 16 Ward)

Registration District No. 701 File No. 30835

Primary Registration District No. 1008 Registered No. 3750

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Owen Sullivan (Illegitimate)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: boy

4 COLOR OR RACE: W.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept. 13, 1918 (Month) (Day) (Year)

7 AGE: ....yrs....mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): "

9 BIRTHPLACE (City or town, State or foreign country): St. Louis, Mo.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown

12 MAIDEN NAME OF MOTHER: Frances Sullivan

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Schroeder
(Address) 3649 Vista Ave.

15 Filed SEP 20 1918, 191.... Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 17, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 13, 1918, to Sept 17, 1918, that I last saw h. alive on Sept 16, 1918, and that death occurred, on the date stated above, at 3 or A.m.

The CAUSE OF DEATH* was as follows:
Prematurity

(Duration) ....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs....mos....ds.

(Signed) H. E. Kimpatrick M. D.
Sept. 18, 1918 (Address) 3603 Humphrey

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs....mos. 4 ds. In the State ....yrs....mos. 4 ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: SEP 20 1918

20 UNDERTAKER: J. L. Edwards ADDRESS: 1426 Carroll St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION [illegible]

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City St Louis (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Celeste Lynn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH: December 3, 1917 (Month) (Day) (Year)

7 AGE: ..... yrs. 9 mos. 7 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September 11, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....

and that death occurred, on the date stated above, at ..... m

The CAUSE OF DEATH* was as follows:

.....

..... (Duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds

(Signed) ..... M. D

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, stat (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS