

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

Do not use this space.

40217

**1. PLACE OF DEATH**

County Dunklin  
Township Fulton  
City..... (No.....)..... St. .... Ward)

Registration District No. 284-403  
Primary Registration District No. 4184

File No.....  
Registered No. 25

**2. FULL NAME**

Carrol Deenzil Sullivan

(a) Residence. No..... St..... Ward.....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Male

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)

Single

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** 11-19-29

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>0</u>	<u>1</u>	<u>2</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Mo.

**10. NAME OF FATHER** John A Sullivan

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Mo.

**12. MAIDEN NAME OF MOTHER** Hazel Myers

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Mo.

**14. INFORMANT** Jno A Sullivan  
(Address) Clarkton Mo

**15. FILED** 12-22-29 J. B. Steinhilber  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 12-21 1929

**17. I HEREBY CERTIFY, That I attended deceased from** 12-14, 1929 to 12-21, 1929  
that I last saw him alive on 12-20, 1929, and that death occurred, on the date stated above, at 6.00 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Erysipelas - 15B  
(Cause unknown - no injury)  
(duration) ..... yrs. .... mos. 8 ds.

**CONTRIBUTORY (SECONDARY)** Jamdis  
(duration) ..... yrs. .... mos. 2 ds.

**18. WHERE WAS DISEASE CONTRACTED?**  
NOT AT PLACE OF DEATH  
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) J. B. Steinhilber, M. D.  
(Address) Clarkton Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Standfield Cem. **DATE OF BURIAL** 12-22 1929

**20. UNDERTAKER** none **ADDRESS**

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.

35  
21 1930

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FEB 19 1961

U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

OFFICE OF THE ASSISTANT SECRETARY FOR  
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