

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

Do not use this space.

6375

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **4240 W Page Blvd**)

File No.....
Registered No. **1144**
St..... Ward.....

2. FULL NAME

Bridget Sullivan
(a) Residence. No..... St. **11** Ward.....
(Usual place of abode) (If nonresident, give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John Sullivan**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Unknown 1858**
7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min. **abt. 72 Unknown**
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **at Home**
(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) **Ireland**
10. NAME OF FATHER **John Connors**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**
12. MAIDEN NAME OF MOTHER **Don't Know**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

14. INFORMANT **Margaret Sullivan**
(Address) **4240 W Page Ave**

15. FILED **F-4-1930** **May 2 1930**
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 1 1930**
17. **HEREBY CERTIFY**, That I attended deceased from **Jan 27 1930**, to **Feb 1 1930**, that I last saw him alive on **Feb 1 1930**, and that death occurred, on the date stated above, at **10:30 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(Anoxia cerebral hemorrhage)
82A (duration) yrs. mos. ds. **4**
77 CONTRIBUTORY **Arterio-sclerosis** (SECONDARY) (duration) yrs. mos. ds. **5**
18. WHERE WAS DISEASE CONTRACTED **at Home**
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS **clinical**
(Signed) **B. Skelley** M. D.
Feb. 1, 1930 (Address) **4500 Olive St**

*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 **Calvary Cemetery** DATE OF BURIAL **2/4 1930**
20. UNDERTAKER **Arthur J. Donnelly** ADDRESS **2039 Wood 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 is very important.

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