

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

Do not use this space.

5583

**1. PLACE OF DEATH**

County Jackson  
Township St. Paul  
City St. Paul (No. St. Lukes Hosp)

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 678  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mrs Phyllis G Sullivan

(a) Residence. No. \_\_\_\_\_ St., \_\_\_\_\_ Ward. Sedalia Mo.  
(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 F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16<sup>th</sup> 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
34 6 25

**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)

Earls  
Kas

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

A. D. Burt  
Ohio  
Noea Burt  
Ohio

**14. INFORMANT**

(Address)

Mrs Dean Gill  
Garden Grove Ia

**15. FILED**

\_\_\_\_\_ 19 \_\_\_\_\_

7/11 31 M. M. Crowe  
Asst REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/11/31 1931

I HEREBY CERTIFY, That I attended deceased from Jan 23 to Feb 11 1931 that I last saw her alive on Feb 10 1931, and that death occurred, on the date stated above, at 5:30 a.m.

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

Quarrel Lepnia  
146A  
107A Septic Pneumonia  
Broncho  
(duration) yrs. mos. 19 ds.  
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 4 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

7 (Signed) H. P. Roush M. D.  
7/11 1931 (Address) 1022 Prof. Bldg

\*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**

DATE OF BURIAL \_\_\_\_\_

Sedalia Mo

7/11/31 1931

**20. UNDERTAKER**

ADDRESS

H. F. Mayberry Co

City

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.

