4 1938 REC'D SEP 9 1938

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

29945
Do not use this space.

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.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 784
(b) Township Clayton — Primary Registration District No. 101 — Registered No. 1321
(c) City Clayton — (d) Street No. St Louis County Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JAQUELINE SULLIVAN 415
(a) Residence, No. ___ St. ☐ Winona Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Mrs Hebert Sullivan (Mrs C. M. Mulgan)
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: YEARS 6 — MONTHS 8 — DAYS — If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at School
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Winona Mo.

FATHER
13. NAME: Mrs Zelpha ~~[illegible]~~
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Shannon Co Mo

MOTHER
15. MAIDEN NAME: Mrs Wollard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Springfield Mo.

17. INFORMANT (ADDRESS): 2963 Ridgeway Wab (1076 Jr) Overland Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Winona Mo DATE 8-5-38 19
19. FUNERAL DIRECTOR (ADDRESS): Parker Und Co Webster Groves Mo
20. FILED AUG 4 1938 19 T. R. Meyer M. Dr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 4, 1938

22. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
Last saw h___ alive on ___, 19___. Death is said to have occurred on the date stated above, at 7AM m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Struck by an automobile while a pedestrain on a public highway.	8/3/38
210 M 21	
Other contributory causes of importance:	
Fractured skull	8/3/38

Name of operation ___ Date of ___
What test confirmed diagnosis? physical signs Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 8/3/38
Where did injury occur? Overland Mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Public place
Manner of injury Struck by automobile
Nature of injury Fracture of the skull

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify ___
(Signed) John O. Powell, M. D.
(Address) Coroner of St. Louis County, Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, L. C. Aldrich, Licensed Embalmer No. 1332

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No: or by , Registered Apprentice No.

working under my personal supervision.

Signed L. C. Aldrich

Licensed Embalmer No. 1332

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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(a) County St Louis — Registration District No. 784
(b) Township Clayton — Primary Registration District No. 101 — Registered No. 1321
(c) City ..... (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jaqueline Sullivan
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-16-1931

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
6	8	18	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

FATHER
13. NAME .....
14. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME .....
16. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

17. INFORMANT ..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19..

19. FUNERAL DIRECTOR ..... (ADDRESS)

20. FILED 8-4, 1938 R. R. Meyer M.D. D.V.M. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4, 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) John O. Connell Coro
(Address) St Louis County

SUPPLEMENTARY

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-29945