

REC'D APR 12 1939

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

8389
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... 2
(b) Township..... Primary Registration District No..... 1003
(c) City 4139 Hull St. St. Louis (d) Street No.....
(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.

Registered No. 2154

2. PRINT FULL NAME MARY SULLIVAN

(a) Residence, No. 4139 Hull Pl. St. 10 (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) MARRIED.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF THOMAS SULLIVAN
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1874-8-15
7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
64 6 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Ireland 5

FATHER 13. NAME 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

MOTHER 15. MAIDEN NAME 9

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

17. INFORMANT (ADDRESS) Mary Sullivan

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery March 9 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John J. Collins 718 Grand Ave

20. FILED MAR 10 1939 J. D. Bishop Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 5th 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 3 1938 to March 5 1939
I last saw her alive on March 5 1939 Death is said to have occurred on the date stated above, at 11 a.m.
The principal cause of death and related causes of importance were as follows:

chronic endocarditis
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? NO
If so, specify.....
(Signed) D. A. P. Drosser, M. D.
(Address) 312 1/2 Grand

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.

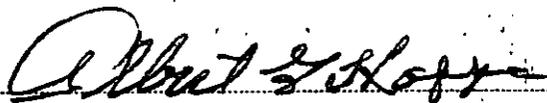
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 2971

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.