

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 590
Registrar's No. 590

Registration District No. 791
Primary Registration District No. _____

1. PLACE OF DEATH: U.P.
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: BARNES HOSPITAL
(d) Length of stay: In hospital or institution 8 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 625 Skinner
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME SUE HICKS SULLIVAN
(b) If veteran, name war none
(c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 20
year 1940 hour 5 minute 9 M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Frank H. Sullivan
6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Oct. 8 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 12 1940, to January 20 1940, and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
Duration 10 days

8. AGE: Years 64 Months 3 Days 12
If less than one day _____ hr. _____ min.

Due to Hypertension and arteriosclerosis
Duration 10 yrs.

9. Birthplace Hempstead Co. Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name James H. Hicks
13. Birthplace unknown Miss.
14. Maiden name Margaret
15. Birthplace unknown Miss.

PHYSICIAN [Signature]
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature F. H. Sullivan
(b) Address 625 Skinner
17. (a) Burial (b) Date thereof 1-22-40
(c) Place: burial or cremation Oak Grove Mausoleum

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director C. R. Lupton & Sons
(b) Address 7233 Delmar Blvd.
19. (a) JAN 21 1940 (b) J. D. [Signature]

23. Signature [Signature] (M. D. or other) _____
Address BARNES HOSPITAL Date signed 1-20-40

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.

STATE OF MISSOURI - DEPARTMENT OF COMMERCE - BUREAU OF THE CENSUS - STANDARD CERTIFICATE OF DEATH

11
Jefferson
ca 1870

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.

590
590

Signed Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address St. Louis, Mo

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.