

No. 2
-1-4-41
5-17-39
PI X25390

DEPARTMENT OF COMMERCE
REGISTERED MAIL
FILED AUG 8 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23436**
Registrar's No. **5788**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis Mo.**
(b) City or town _____
(c) Name of hospital or institution: **DePaul Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 weeks** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5015 St. Louis**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Jeremiah Sullivan**
3. (b) If veteran, name war _____
3. (c) Social Security No. **488-05-725**

4. Sex **M.** 5. Color or race **W.**
6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife **Florence Sullivan**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 3. 1886**
(Month) (Day) (Year)

8. AGE: Years **55** Months **5** Days **10**
If less than one day _____ hr. _____ min.

9. Birthplace **Boston, Mass.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nightwatchman**

11. Industry or business _____

MOTHER FATHER {
12. Name **Jeremiah Sullivan**
13. Birthplace **Ireland** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Ireland** (City, town, or county) (State or foreign country)

16. (a) Informant **Jerome Sullivan**
(b) Address **5015 St. Louis**

17. (a) **Burial** (b) Date thereof **7/16/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Sullivan Und.**

18. (a) Signature of funeral director _____
(b) Address **2849 N. Euclid**

19. (a) **JUL 14 1941** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **July** day **13**,
9 year **1941** hour **10** minute **30** am.

21. I hereby certify that I attended the deceased from **July 2** 19**41** to **July 13** 19**41**;
that I last saw him alive on **July 13** 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial chronic**
hypertensive chronic
Due to _____
Due to _____

Other conditions **essited**
(Include pregnancy within 3 months of death)

Major findings: Of operations **1316**
Of autopsy _____

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

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? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **W.E. Markin** (M. D. or other) **MD**
Address **4005 W. Flanagan** Date signed **7/14/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Duration

MOTHER FATHER

Mr. Morris
4005 N. Florida
Do: 1250
11/1/50

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..... *Albert Mayfield*

Licensed Embalmer No..... *3577*

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, fact should be so stated above.