

FILED AUG 28 1941 7 9 1

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5-days**
In this community **0** years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Lucy Sullivan**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W.**

6. (b) Name of husband or wife **Daniel Sullivan** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Unk. Unk. 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 Unk. Unk. hr. min.

9. Birthplace **Ill. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **St Home**

11. Industry or business.....

MOTHER FATHER { 12. Name **Michael Tracy**
13. Birthplace **Ireland 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Chas. A. Stuever**

(b) Address **# 3 Ladue Lane**

17. (a) **Burial** (b) Date thereof **7-24-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **JUL 23 1941** (b) **J. M. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **000 17**
(c) City or town **St. Louis** **5 9**
(If outside city or town limits, write "RURAL")
(d) Street No. **5638 Kingsbury**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **22nd.** year **1941** hour **5** minute **0** M.

21. I hereby certify that I attended the deceased from **June 10** 1941 to **July 22** 1941
that I last saw her alive on **July 21** 1941
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Hypostatic congestion of lungs & atelectasis, no pneumonia 18 hours
Due to **Cerebral arteriosclerosis** **36 11**
in coma.

Other conditions.....
(Include pregnancy within 3 months of death) **97**

Major findings:
Of operations.....
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?.....

(Specify type of place) While at work..... (e) Means of injury.....
23. Signature **John J. Kammann** M. D. or other **MD**
Address **634 N. Grand Blvd.** Date signed **7/22/41**

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.