S. No. 2
M—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3627

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2627

1. PLACE OF DEATH:

(a) County: St. Louis County

(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm. 12/15/44 (Specify whether
In this community 58 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: St. Clair

(c) City or town: East St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 550 N. 19th Street
(If rural, give location)

(e) Citizen of foreign country? - (Yes or No)

If yes, name country -

3. (a) PRINT FULL NAME: SULLIVAN, William J.

3. (b) If veteran, name war: World War #1

3. (c) Social Security No.: unknown.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mrs. Nell Sullivan

6. (c) Age of husband or wife if alive: 51 years

7. Birth date of deceased: July (Month) 30, (Day) 1886 (Year)

8. AGE:

Years	Months	Days	If less than one day
58	5	0	hr. min.

9. Birthplace: East St. Louis (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: Mail Carrier

11. Industry or business: -

FATHER
12. Name: Patrick Sullivan
13. Birthplace: (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Catherine Quirk
15. Birthplace: (City, town, or county) Ireland (State or foreign country)

16. (a) Informant:
(b) Address: Clinical Records, VAF, Jeff. Bks., Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-31-44 (Month) (Day) (Year)
(c) Place: burial or cremation: East St. Louis, Ill.

18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.

19. (a) JAN 8 1945 (Date received local registrar) (b) E. L. McGaveran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30th, year 1944 hour 12:05 minute P. M.

21. I hereby certify that I attended the deceased from December 15, 1944 to December 30 1944 that I last saw him alive on December 30 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
BRONCHOPNEUMONIA.	10 Days
Due to -	
Due to -	
Other conditions (Include pregnancy within 3 months of death) Arteriosclerosis, cerebral and general.	Unkn.

Major findings: Of operations: None.

Of autopsy: No 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): no
(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: W. A. GERMAN, M.D. (M. D. or other)
Address: MANAGER Date signed 12/30/44

(Licensed Embalmer's Statement on Reverse Side)

OCT 1 1945

FEB 26 1945

MAR 2 1945

FEB 20 1945

FEB 1 1945

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 G. Hafke

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, fact should be so stated above.