

FILED JUN 11 1945

Registration District No. 317

Primary Registration District No. 13066

1309

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Kirkwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
418 N. Taylor  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St Louis  
(c) City or town Kirkwood  
(If outside city or town limits, write "RURAL")  
(d) Street No. 418 N. Taylor Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert Brent Sullivan

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 499-01-3169

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive \_\_\_\_\_ years

7. Birth date of deceased Sept 17 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 8 18 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Memphis Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business Union Electric Co.

MOTHER FATHER { 12. Name John Sullivan  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Sally Prick  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs James Hitt  
(b) Address New Berlin, Ill.

17. (a) Burial (b) Date thereof 6-6-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Louis H. Boop, Inc.  
(b) Address Kirkwood, Mo.

19. (a) JUN 7 1945 (b) E. G. M. Gauran  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5  
year 1945 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from December 1944 to June 5 1945  
that I last saw him alive on June 4 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung - R. Bronchus  
Due to \_\_\_\_\_  
Due to 47d

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 H. A. ... (M. D. or other) \_\_\_\_\_  
Address 19 E. Kirkwood Date signed 6/6/45

Duration

7 Mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MAR 24 1955

**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..... *Van M. Simon* .....

Licensed Embalmer No. *4343* .....

P. O. Address..... *7415 Zephyrus Pl.  
Waukegan, Ill.* .....

**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.**