7

7-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6204

Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 14

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town De Soto
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1207 Boyd St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jefferson 50
(c) City or town De Soto 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1207 Boyd St. 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country ✓

3. (a) PRINT FULL NAME John Daniel Sullivan

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 0 5. Color or race White 6. (a) ~~Single,~~ widowed, ~~married, divorced~~ 3

6. (b) Name of husband or wife Paulina Hopson 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased Oct. (Month) 8 (Day) 1852 (Year)

8. AGE: Years 83 Months 3 Days 28 If less than one day ___ hr. ___ min.

9. Birthplace Old Mines (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Ret. Forman Machine Shop

11. Industry or business Mo. Pac. RR. Shops

FATHER
12. Name William Sullivan
13. Birthplace Old Mines (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Lucretia Portell
15. Birthplace Old Mines (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Mrs Eva West
(b) Address 3651 Hickory St St Louis Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-46 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary - De Soto, Mo

18. (a) Signature of funeral director J. Lee Mothershead
(b) Address De Soto - Mo.

19. (a) 2/25/46 (Date received local registrar) (b) Marie Farris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6
year 1946 hour — minute — M.

21. I hereby certify that I attended the deceased from Feb 1, 1946 to Feb, 19__
that I last saw him alive on Feb 4, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Angina Pectoris - sudden	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 940	

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 0

23. Signature Walter E. Gibson (M. D. ~~or other~~)
Address 401 S. 5th De Soto Mo. Date signed Feb 7 46

146

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 3-6-46

MAR 19 1946

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: Joe Molkenshead

Licensed Embalmer No. 3531

P. O. Address Desoto Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
I X43880

WRITE PLAINLY—USE INDIA INK, BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 14

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town De Soto
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME John D. Sullivan
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wd
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Oct (Month) 8 (Day) (Year)
8. AGE: Years 83 Months 3 Days 24 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant (Mrs Eva West)
(b) Address 3765 Hickory St. St Louis Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Marie Farris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1946 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

6204