

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18764**  
Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4404**

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: 5546 Herbert  
(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)

3. (a) PRINT FULL NAME Algail O'Brien  
3. (b) If veteran, name war. No. 9  
3. (c) Social Security No. 9

5. Color White 6. (a) Single, widowed, married Married  
race White divorced  
6. (c) Age of husband or wife if alive. 1878  
7. Birth date of deceased April 4 (Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days 9 If less than one day hr. min.

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business At Home

12. Name James M. Sullivan

13. Birthplace Lawrence, Ohio (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth

15. Birthplace Brooklyn, New York (City, town, or county) (State or foreign country)

16. (a) Informant James M. Sullivan

(b) Address 1745 Harris River

17. (a) Burial May 17-46 (Burial, cremation, or otherwise) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic

18. (a) Signature of funeral director Chas. F. Stuart

(b) Address Union Blvd

19. (a) MAY 18 1946 (Date received local registrar)

(b) J. F. Bradeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 5546 Herbert  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 13 year 1946 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from Jan 4 to May 13 1946  
that I last saw her alive on May 6 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: AC cardiac dilatation  
Chor myocardiitis  
Due to 7. hypertension  
Due to arteriosclerosis  
Chronic nephritis

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations 121

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 Samuel Webb (M.D. or other)

Address 2906 N. Union Date signed 5/14/46

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**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 John J. Gonsowski  
Licensed Embalmer No. 3398

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.**