

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3182

FILED JAN 27 1948

Registration District No. Primary Registration District No. 1003 Registrar's No. 357

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(b) City or town  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Hospital  
(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)

3. (a) PRINT  
FULL NAME

Patrick Sullivan

3. (b) If veteran,

name war.

3. (c) Social Security

No. 499-28-8196

4. Sex Male  
5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Johanna Bresnahan  
6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased March 17 1887  
(Month) (Day) (Year)

8. AGE: 59 Years 9 Months 24 Days  
If less than one day hr. min.

9. Birthplace Kerry Ireland  
(City, town, or county) (State or foreign country)

10. Usual occupation Stationary Fireman

11. Industry or business City of St. Louis

12. Name Michael Sullivan

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

14. Maiden name Johanna Pierce

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Johanna Sullivan

(b) Address 4235 Labadie ave.

17. (a) Burial (b) Date thereof 1-14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan Bro's

(b) Address 2849 N. Solid ave.

(a) 13 1947 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4235 Labadie ave.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11  
year 1947 hour 7 min. 30 A. M.

21. I hereby certify that I attended the deceased from  
19 to 19  
that I last saw h. alive on  
and that death occurred on the date and hour stated above.  
Immediate cause of death  
Duration

Carcinoma of lungs

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?

While at work? (Specify type of place)

Means of injury

23. Signature (M. D. or other)

Address Date signed

Coroners Case.

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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.....

Licensed Embalmer No. ....

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.