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MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34744**

FILED OCT 30 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9436**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 0 (Specify whether  
in this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME JOSEPH SULLIVAN

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARY 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased DEC 23 - 1876  
(Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation UNKNOWN

11. Industry or business \_\_\_\_\_

12. Name PATRICK SULLIVAN

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

14. Maiden name ELIZABETH U.K.

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

16. (a) Informant MARGARET KELLY

(b) Address 2331 MULLANPHY

17. (a) BURIAL (b) Date thereof 10-20-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SALVARY

18. (a) Signature of funeral director Gullen - Kelly

(b) Address 4386 Lindell

19. (a) OCT 19 1948 (b) J. A. Larater  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS  
(If outside city or town limits, write "RURAL")  
(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3534 PAGE Memorial  
(If rural, give location)  
(e) Citizen of USA country? (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16th  
year 1948 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 10/13/48  
to 10/16/48  
that I last saw him alive on Oct. 16th  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of Cerebral Artery  
Due to Atherosclerosis

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

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

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature M. Luster M.D. Date signed 10/18/48  
Address 1515 Lafayette  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

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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 Ralph W. Jensen

Licensed Embalmer No. 3791

P. O. Address St. Louis, Mo

**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.**