No. 300
10-48

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

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21750

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5114

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5187 Maple Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 5187 Maple Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Oneida
b. (Middle)
c. (Last) Sullivan

4. DATE OF DEATH (Month) June (Day) 12 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Jan. 25, 1877
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Anna, Illinois
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Eliphalet Hale
13b. MOTHER'S MAIDEN NAME Eliza Bell
14. NAME OF HUSBAND OR WIFE John T. Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Margaret C. Sullivan, **ADDRESS** 5187 Maple Av.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Usual
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cardio-Vascular-Renal Disease 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 12, 1949, *to* June 12, 1949, *that I last saw the deceased alive on* June 11, 1949, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Leon C. Hale (Degree or title) M.D.
23b. ADDRESS 1504 So. Grand Blvd
23c. DATE SIGNED 6-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 14, 49
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. JUN 14 1949
REGISTRAR'S SIGNATURE J. B. Lossler
25. FUNERAL DIRECTOR'S SIGNATURE Cullinane Bros. **ADDRESS** 3320 N. Kingshighway

(Licensed Embalmer's Statement on Reverse Side)

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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Signed Fred Frick

Signed .....
Student Embalmer

Licensed Embalmer No. 3186

P. O. Address St. Louis, Mo.

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

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