

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35627
State File No. 35627
Registrar's No. 9334

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY St. Louis Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE mo b. COUNTY 011	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo. 9		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 13- 5400 Arsenal St.	

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) SULLIVAN c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Oct. 5, 1949	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1867
9. AGE (In years) (Month) (Day) abt 82		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) England 4		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Michael Sullivan	13b. MOTHER'S MAIDEN NAME Eliabeth Driscol	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS St. Louis State Hospital

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arterio-sclerosis		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		10yrs.x
*This does not mean the mode of dying, such as heart failure, asthemia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c)		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	

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) 97
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500

22. I hereby certify that I attended the deceased from **Jan. 1, 1945**, to **Oct. 5, 1949**, that I last saw the deceased alive on **Oct. 5, 1949**, and that death occurred at **1.15 p.m.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Lowry Brown, M.D.	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 10/7/49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Oct 3, 1949	24c. NAME OF CEMETERY OR CREMATORY Assumption	24d. LOCATION (City, town, or county) (State) --
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DATE REC'D BY LOCAL REG. OCT 31 1949	REGISTRAR'S SIGNATURE J B Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

Rowland Mortuary Service Inc

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

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.

Student
Student Embalmer

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.