

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3077
State File No.
Registrar's No. 138

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY OR TOWN St. Louis, Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2927 Allen | | d. STREET ADDRESS (If rural, give location) 2927 Allen | |

3. NAME OF DECEASED (Type or Print) a. (First) **Dr. Francis C. Sullivan** b. (Middle) **17** c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) **Jan. 3, 1950**

| | | | | | | | |
|--------------------|-------------------------------|---|-------------------------------------|---|------------------------|------------------------|------|
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 9, 1897 | 9. AGE (In years last birthday) 52 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | Min. |
|--------------------|-------------------------------|---|-------------------------------------|---|------------------------|------------------------|------|

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

| | | |
|--|--|---|
| 13a. FATHER'S NAME Thomas F. Sullivan | 13b. MOTHER'S MAIDEN NAME Catherine Cline | 14. NAME OF HUSBAND OR WIFE Anita Sullivan |
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|--|---|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | 16. SOCIAL SECURITY NO. World War II | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Anita Sullivan | ADDRESS |
|--|---|--|---------|

| | | |
|---|---|----------------------------------|
| 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. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis Acute Cardiac Dilatation Chest Constriction DUE TO (b) Chronic Asthma DUE TO (c) | INTERVAL BETWEEN ONSET AND DEATH |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

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

22. I hereby certify that I attended the deceased from **July 1938** to **6 Jan 1950**, that I last saw the deceased alive on **1-3**, 1950, and that death occurred at **4:15 a.m.**, from the causes and on the date stated above.

| | | |
|--|------------------------------------|------------------|
| 23a. SIGNATURE (Degree or title) Roy L. Tate M.D. | 23b. ADDRESS 901 Washington | 23c. DATE SIGNED |
|--|------------------------------------|------------------|

| | | | |
|---|-------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 1-6-50 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
|---|-------------------------|--|---|

| | | | |
|--------------------------|--|---|------------------------------------|
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home | ADDRESS 6322 S. Grand Blvd. |
|--------------------------|--|---|------------------------------------|

JAN 6 1950

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

JAN 20 1950

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 *David Jan Fossan*

Licensed Embalmer No. *4242*

P. O. Address *6322 So Grand. ar*

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.