

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32255**  
Registrar's No. **7841**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		e. STREET ADDRESS (If rural, give location) <b>1842<sup>nd</sup> St. Fallons 219</b>	

3. NAME OF DECEASED (Type or Print) <b>William Sullivan</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 22, 1954</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 4, 1905</b>	9. AGE (In years last birthday) <b>49</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Lake Providence La.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Sullivan</b>	13b. MOTHER'S MAIDEN NAME <b>Bell</b>	14. NAME OF HUSBAND OR WIFE <b>Ethel Sullivan</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>430-30-8232</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Ethel Sullivan</b>	ADDRESS <b>1842<sup>nd</sup> Fallons</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <b>Lung Abscess</b>		
	DUE TO (c) <b>Arterial Hypertension-Sclerosis</b>		
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>446X</b>

22. I hereby certify that I attended the deceased from 19, to 19, that I last saw the deceased alive on 19, and that death occurred at 11:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Patrick F. Taylor Carver</b> (Degree or title)	23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>8.25.54</b>
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24a. BURIAL, CREMATION, REMOVAL <b>Removal</b>	24b. DATE <b>Aug. 28, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>AUG 24 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. B. Kooze</b>	ADDRESS <b>1221 N Grand</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Malvin Blackman*

Licensed Embalmer No. *3462*

P. O. Address *1221 N. 4th*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.