

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1957

318

1003

STATE FILE NUMBER 3123
REGISTRATION DISTRICT NO. 494

Registration District No. Primary Registration District No. Registrar's 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 (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Mo. 470 Washington				Length of stay in 15 12 d. STREET ADDRESS 5151 Delmar Blvd.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Daisy Middle DEAN Last SULLIVAN				4. DATE OF DEATH Month 1 Day 15 Year 57				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-1872		9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months 6 Days 9 IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Work			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Greencastle Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Danaho				14. MOTHER'S MAIDEN NAME E. Frances Mullin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) No			16. SOCIAL SECURITY NO. 49-09-5146		17. INFORMANT Masonic Home of Missouri Louis C. Robertson Supt.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION							INTERVAL BETWEEN ONSET AND DEATH ONE DAY	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE							ONE YEAR	
DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED							10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF RIGHT BREAST WITH GENERALIZED METASTASES							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 420-0 H						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. 		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from JAN - 1956 to JAN 15, 1957 and last saw her ^{her} _{him} alive on 1-13-57 Death occurred at 8:50 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Robert A. Hall				22b. ADDRESS M. D. 5381 DELMAR ST. LOUIS, Mo		22c. DATE SIGNED JAN 15, 1957		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-17-57	23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		23d. LOCATION (City, town, or county) (State) Okawville, Ill.			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,				25. DATE RECD. BY LOCAL REG. JAN 16 '57		26. REGISTRAR'S SIGNATURE Pearl Smith M.D. mfb.		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

Health,
Welfare
Public
Service

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 Robert M. Murray

Licensed Embalmer No. 13

P. O. Address H. Lewis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.