

Health,
S. Welfare
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38210

STATE FILE NUMBER

FILED NOV 6 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 9481

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Dellwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in lb 1 week	d. STREET ADDRESS (If outside, give location) 51 S. Dellwood		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last E dna Sullivan			4. DATE OF DEATH Month Day Year Oct. 10 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19 1891		9. AGE (In years last birthday) 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Albert A. Carter		13b. MOTHER'S MAIDEN NAME Not Known		14. NAME OF HUSBAND OR WIFE Robert L. Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles Sullivan 51 S. Dellwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident arteriosclerotic hypertensive disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Hypertension over 10 yrs DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Osteoarthritis, Osteoporosis					INTERVAL BETWEEN ONSET AND DEATH 2 wks
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.) 260x		
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 18 Oct 57 to 10 Oct 57 and last saw her alive on 9 Oct 57 Death occurred at 3:00 AM 3 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Eugene W. Hall (Degree or title) M.D.		22b. ADDRESS 116a S. Florissant Rd. 116 S. Florissant Rd. 100157		22c. DATE SIGNED 10-10-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 10/11/57		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
24. FUNERAL DIRECTOR Buchholz Mortuary		ADDRESS 5967 W. Florissant		25. DATE RECD. BY LOCAL REG. OCT 10 57	
				26. REGISTRAR'S SIGNATURE Paul Smith MD mfs	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

STATEMENT BY LICENSED EMBALMER

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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 *John S. Demme*

Licensed Embalmer No. *4194*

P.O. Address *St. Louis*

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.