

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011895

STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 767

300
1-57
291
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>1</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROBT KOCH HOSP</u>		Length of stay in lb <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>2640 SPRUCE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARCELLUS SULLIVAN</u>				4. DATE OF DEATH Month Day Year <u>MAR 16 1959</u>			
5. SEX <u>M</u>	2	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> -3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JUN 13 1904</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and state or county) <u>Choneyville, La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>GENERAL SULLIVAN</u>			13b. MOTHER'S MAIDEN NAME <u>C. REED</u>		14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>489-16-9717</u>		17. INFORMANT Address <u>HOSPITAL RECORD - KOCH HOSPITAL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						.002X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Death occurred at <u>MAR 14/59</u> to <u>MAR 16/59</u> and last saw him alive on <u>MAR 16/59</u> <u>10:15 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank Cohen MD</u>			22b. ADDRESS <u>Robert Koch Hosp Koch Mo</u>		22c. DATE SIGNED <u>MAR 17/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
24. FUNERAL DIRECTOR <u>G. Wade Granberry</u>		ADDRESS <u>4202 Finney</u>		DATE RECD. BY LOCAL REG. <u>3-20-59</u>		26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>	

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 *Edward K. Flynn*

Licensed Embalmer No. *4444*

P. O. Address *4202 Finne*

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.