

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

25491

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis Mo.* (No. *City Infirmary*)..... St. Ward)

File No.
Registered No. **7073**.....

2. FULL NAME *John L Sullivan*

(a) Residence No. *City Infirmary* St. **13** Ward.

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* | 4. COLOR OR RACE *white* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>about 81</i>	<i>—</i>	<i>—</i>	<i>—</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *unemployed*
(b) General nature of industry, business, or establishment in which employed (or employer) *Labor*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

10. NAME OF FATHER *Dennis Sullivan*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

12. MAIDEN NAME OF MOTHER *Mary Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

14. INFORMANT *Debitis H. Lohr*
(Address) *5600 Arsenal*

15. AIG - 1 1927 *Mar 6 Starckoff*
FILED 19 _____ REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8/2 1927*

17. I HEREBY CERTIFY, That I attended deceased from *11/24*, 19*24*, to *8/2*, 19*27*, that I last saw him alive on *8/2*, 19*27*, and that death occurred, on the date stated above, at *9:55 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Apoplexy (Cerebral Hemorrhage)
Arteriosclerosis, General
Chronic Myocarditis*
(duration) *2 yrs. 8 mos. 10 da.*

CONTRIBUTORY (SECONDARY) *90%*
(duration) yrs. mos. da.

18. *90%* WERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. *5800 Arsenal*

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*
(Signed) *Arthur H. Lohr*, M. D.

(Address) *17600 Arsenal St*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Calvary Cemetery Aug 4 1927

20. UNDERTAKER ADDRESS

E. J. Schur 3125 Lafayette

WRITE PLAINLY, WITH UNFADING INK---THIS IS PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

