WRITE PLAINLY, WITH UNFADING INK--THIS IS A 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.

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

Do not use this space.

18028

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St Louis mo (No. City Hospital #1 St. ..... Ward)

File No. .....

Registered No. 4227

2. FULL NAME John D. Cullen

(a) Residence, No. 1506 California 23 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 8-30-1868

7. AGE: Years 64 | Months 8 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Waiter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): New York

FATHER

13. NAME: James Cullen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

MOTHER

15. MAIDEN NAME: Ellen Maher

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

17. INFORMANT (ADDRESS): Julia Cullen 1506 California

18. BURIAL, CREMATION, OR REMOVAL

PLACE: Calvary DATE: 5-13 1933

19. UNDERTAKER (ADDRESS): Guy Mullen 4059 Lindell

20. FILED: MAY 12 1933 19 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

No physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 10, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ..... 905 19..... Death is said to have occurred on the date stated above, at 9 a.m.

The principal cause of death and related causes of importance were as follows:

Gun Shot Wound of head

Self Inflicted

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Other contributory causes of importance:

Suffering temporary mentage aberrations

Date of onset

Name of operation ..... Date of ..... No

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Suicide Date of injury 5/8/33

Where did injury occur? St Louis Mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury .....

Nature of injury Gun Shot Wound of head.

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) John J. Sweeney, M.D.

(Address) Deputy Coroner

5/11/33