

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

FFB 12 1938

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

696
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **DePaul Hospital** Registered No. **552**
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Elizabeth Sullivan
(a) Residence, No. **5105 Vernon Ave.** St. **5**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ernest Sullivan		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 2, 1862		
7. AGE YEARS 75	MONTHS 8	DAYS 13
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home	
	9. Industry or business in which work was done, as 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) Ireland	5	
FATHER	13. NAME Michael McGrath	5
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland	5
MOTHER	15. MAIDEN NAME Annastacia Maher	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland	
17. INFORMANT Mr. Francis J. Sullivan (ADDRESS) 6021 Pershing Ave.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE Jan. 18, 1938		
19. FUNERAL DIRECTOR Arthur J. Donnelly Undt. Co. (ADDRESS) 3840 Lindell Blvd.		
20. FILED JAN 17 1938 J. Bredbeck Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 15, 1938**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 3rd**, 19**38**, to **Jan 15th**, 19**38**
I last saw her alive on **Jan 15th**, 19**38** Death is said to have occurred on the date stated above, at **8 PM**
The principal cause of death and related causes of importance were as follows:
Braeco Pneumonia **1/15/38**
Other contributory causes of importance: **Chronic Dehydration**
Name of operation..... Date of.....
What test confirmed diagnosis? **Chloroform** Was there an autopsy?.....
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....
24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify **James A. Sullivan**, M. D.
(Signed) **James A. Sullivan**
(Address) **2864th Union Bl.**

STATEMENT BY LICENSED EMBALMER

I, Stanley Marchlewski, Licensed Embalmer No. 2868

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Stanley Marchlewski

Licensed Embalmer No. 2868

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.)