. 2
3-40
7-39
X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 25 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30119

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 7396

1. PLACE OF DEATH:

(a) County

(b) City or town ST LOUIS. MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: DE PAUL HOSPITAL.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County

(c) City or town ST LOUIS. 5
(If outside city or town limits, write "RURAL")

(d) Street No. 1217. HAMILTON AVE
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CATHERINE SULLIVAN.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED.

6. (b) Name of husband or wife HENRY. P. SULLIVAN

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased JUNE. (Month) 14. (Day) 1873 (Year)

8. AGE: Years 67. Months 2 Days 17. If less than one day hr. min.

9. Birthplace MO. (City, town, or county) 0 (State or foreign country)

10. Usual occupation AT HOME 5

11. Industry or business 5

MOTHER FATHER
12. Name BRYAN. TIGHE
13. Birthplace IRELAND. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace IRELAND. (City, town, or county) (State or foreign country)

16. (a) Informant Grace Sullivan
(b) Address 1217. HAMILTON AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-4-1940 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY.

18. (a) Signature of funeral director L. M. Mullen
(b) Address 5165 DELMAR. BLVD.

19. (a) SEP 3 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1
year 1940 hour One minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug. 29, 1940, to Sept. 1, 1940
that I last saw her alive on Aug 31 10:00 P.M., 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac failure	
no definite heart disease	
Due to Bronchial pneumonia	
acidosis.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

107a

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Wm. Wilson M.D. (M. D. or other)
Address 6149a Natural Bridge Date signed 9/2/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....3880

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.