

**1. PLACE OF DEATH:**  
 (a) County ST. LOUIS  
 (b) City or town KOCH, MO  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Robert KOCH HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 weeks, 24 days  
 In this community life  
 years, months or days (Specify whether)

**3. (a) PRINT FULL NAME** John JOSEPH SULLIVAN  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 491-18-8279

4. Sex MO 5. Color or race wh  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)  
 7. Birth date of deceased July 4 1884  
 (Month) (Day) (Year)

**8. AGE:** Years 60 Months 6 Days 22 If less than one day hr. min.

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

10. Usual occupation PAINTER

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 12. Name John SULLIVAN  
 13. Birthplace IRELAND  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant ROBERT KOCH HOSPITAL RECORDS

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 1/31/45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge

19. (a) JAN 31 1945 (b) E. J. McLaughlin  
 (Date received, local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MO (b) County 000  
 (c) City or town ST LOUIS  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 9 ANO 4130  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month January day 26  
 year 1945 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from May 2 1944 to January 26 1945  
 that I last saw him alive on January 26 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure

Due to Hypertensive Heart disease

Due to \_\_\_\_\_  
 Other conditions Pulmonary Tuberculosis  
 (Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy 1361  
 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 0

Signature Bernard Friedman (M. D. or other) M.D.  
 Address Robert Koch Hospital, Koch, Mo. Date signed 1-28-45

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

**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..... *Alfred J. Boedeker*  
.....  
..... Licensed Embalmer No. *2663*  
..... P. O. Address *5939 Alpha*

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