

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED FEB 24 1945

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1323**

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

106
17
9

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)

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

In this community 55 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
15 6

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5735 Theodosia Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Michael J. Sullivan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8,
year 1945 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nellie Sullivan 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Jan. 2nd 1870
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>1</u>	<u>6</u>	hr. _____ min. _____

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____ 13

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

10. Usual occupation Laborer Retired
Laclede Gas Co.

Other conditions 13
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name Michael Sullivan

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cronin

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. William Nigev

(b) Address 5735 Theodosia Ave.

17. (a) Burial (b) Date thereof 2-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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? _____

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) FEB 10 1945 (b) J. F. Brudwick
(Date received for filing) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Albie J. Perry (M. D. or other) _____
Address 1216 E. 12th St Date signed 2/10/45

Coroner's Office

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 *W Van Matre*.....

Licensed Embalmer No. *2825*.....

P. O. Address *4340 Lafayette*.....

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.