

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
Street No. 510 Market St., 9  
Memorial 25 (If rural, give location) 0  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

**FRANK SULLIVAN**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No.

492-22-8864

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 7th  
(Month) (Day) (Year)

1918

8. AGE: Years 65 Months 1 Days 18

If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_

Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation

Laborer

11. Industry or business

Railroad gang

MOTHER FATHER { 12. Name

James Sullivan

13. Birthplace

Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name

Mary Unknown 9

15. Birthplace

Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant MISS BUREN

(b) Address 2331 MULLENPHY

17. (a) BURIAL  
(Burial, cremation, or removal)

(b) Date thereof 6-30-48  
(Month) (Day) (Year)

(c) Place: burial or cremation SALVARY

18. (a) Signature of funeral director

Samuel Kelly

(b) Address 4386 Lindell

19. (a) JUN 30 1948 (b) \_\_\_\_\_  
(Date received local registrar)

J. F. Bradach  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th  
year 1948 hour 12 minute 25 P.M.

21. I hereby certify that I attended the deceased from 6/4/48  
\_\_\_\_\_ 19 \_\_\_\_\_ to June 25th 19 48  
that I last saw him alive on June 25th 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary tuberculosis, far advanced

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Henry A. Atkinson (M. D. or other) M. D.  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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**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 *Not Embalmed*.....

Licensed Embalmer No.....

P. O. Address.....

**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.**