

FILED MAR 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10690
Registrar's No. 1983

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3247 GEYER AV.			d. STREET ADDRESS (If rural, give location) 17 3247 GEYER AV.		
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) E. c. (Last) SULLIVAN.			4. DATE OF DEATH (Month) (Day) (Year) FEB. - 26 - 51		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED - NEVER MARRIED - WIDOWED, DIVORCED (Specify) WIDOW.	8. DATE OF BIRTH Dec-5-1865	9. AGE (In years last birthday) 85 YRS	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) INDIANA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME OWEN FITZPATRICK		13b. MOTHER'S MAIDEN NAME CATHERINE KEEGAN.	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME Ms. J. B. Haring		ADDRESS 3247 Geyer Av.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Arteriosclerotic Heart Disease	
19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H-200			
22. I hereby certify that I attended the deceased from Aug , 19 46 , to Feb 26 , 19 51 , that I last saw the deceased alive on Feb 25 , 19 51 , and that death occurred at 6 P. m. , from the causes and on the date stated above.					
23a. SIGNATURE JOHN B. MICHAEL REE		23b. ADDRESS 2816		23c. DATE SIGNED 2/27/51	
24a. BURIAL, CREMATION, REMOVAL _____		24b. DATE 3-1-51		24c. NAME OF CEMETERY OR CREMATORY _____	
24d. LOCATION (City, town, or county) (State) BRAZIL - INDIANA.		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schmur		ADDRESS 3125 Lafayette St	
DATE REC'D BY LOCAL REG. MAR 1 1951		REGISTRAR'S SIGNATURE J B Lasater		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schmur	

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student embalmer No.....

Signed.....

Joseph B. Ballmer

Signed.....
Student Embalmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Papey St*

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.