

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044701

STATE FILE NUMBER

159

5591

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Registration District No. Primary Registration District No. Registrar's No.

FILED DEC 30 1958

300 4
1-57

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hillsboro		c. CITY OR TOWN St. Louis <i>2069</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Castle Acres Nursing Home		d. STREET ADDRESS 2864a N Union (If outside, give location)	
3. NAME OF DECEASED (Type or print) James A Sullivan		4. DATE OF DEATH Dec. 21, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Cairo, Illinois
13a. FATHER'S NAME James S Sullivan		13b. MOTHER'S MAIDEN NAME Hannah Smith	14. NAME OF HUSBAND OR WIFE Ethelynn Weisert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unk	17. INFORMANT Address Ethelynn Sullivan 300 N 5th E St. Louis, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Gen. arterio-sclerotic DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x			INTERVAL BETWEEN ONSET AND DEATH Dec 14, 58 years
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan 11, 1958 to Dec 21, 58 and last saw him alive on Dec 21, 58 Death occurred at 130P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Doyle W. Ministry M.D.		22b. ADDRESS Des Moines, Mo.	22c. DATE SIGNED Dec 23, 58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/23/58	23c. NAME OF CEMETERY OR CREMATORY National Cem.	23d. LOCATION (City, town, or county) (State) Jefferson Bke. Mo
24. FUNERAL DIRECTOR ADDRESS Edward Fendler 5611 South Grand Blvd.		25. DATE RECD. BY LOCAL REG. 12-22-58	26. REGISTRAR'S SIGNATURE Walter Burdick Dep

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

RECEIVED
DEC 29 1958

JAN 5 1959

JAN 9 1959

JAN 11 1959

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Walter B. Jaella Jr*
Licensed Embalmer No. *4950*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.