

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

5149

STATE FILE NUMBER  
- 62-021059

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5149**

**FILED MAY 31 1962**

1. PLACE OF DEATH  
a. COUNTY **Mo.** b. COUNTY **St. Louis** admission)

b. CITY (If outside corporate limits, give TOWNSHIP only) **St. Louis** Length of stay in 1b

c. CITY OR TOWN **Sappington** Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location) **St. John's Hospital** Inside Limits Yes  No

d. STREET ADDRESS (If outside, give location) **4353 S. Lindbergh Blvd.** Reside on Farm Yes  No

3. NAME OF DECEASED First **Michael** Middle **Lewis** Last **Sullivan** 4. DATE OF DEATH Month **5-** Day **19-** Year **62**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH **5-19-62** 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min **7 32**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Bryan Sullivan** 13b. MOTHER'S MAIDEN NAME **Norma Bobble** 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) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Mrs. Norma Sullivan 4353 S. Lindbergh Bl.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Prematurity 2lbs 7oz**  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **30 weeks gestation**  
DUE TO (c) **776X**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  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 **Birth (May 14)** to **May 19, 1962** and last saw her/him alive on **May 19, 1962**  
Death occurred at **2:00 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **Richard M. Nucherman M.D.** (Degree or title) 22b. ADDRESS **634 N. Grand** 22c. DATE SIGNED **May 21, 1962** (Date)

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **May 22, 1962** 23c. NAME OF CEMETERY OR CREMATORY **Resurrection Cemetery** 23d. LOCATION (City, town, or county) **St. Louis Co. Mo.**

24. FUNERAL DIRECTOR **Kriegshauser 4228 S. Kingshighway Blvd.** ADDRESS **MAY 21 1962** 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE **Loan Smith, M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

**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 R. W. Stovesund

Licensed Embalmer No. 4007

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