

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048785

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 12571

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JAN 10 1963**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY -		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in 1b <b>2 1/2 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Louis County</b>		c. CITY OR TOWN <b>Warson Woods</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Lukes Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>848 Renderer Drive</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A/K as Mary K</b> Last <b>Sullivan</b>						4. DATE OF DEATH Month <b>12</b> Day <b>29</b> Year <b>62</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-17-20</b>		9. AGE (last birthday) <b>42</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ticket agent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>American Air Lines</b>		11. BIRTHPLACE (City and state or country) <b>Manchester, N.H.</b>		12. CITIZEN OF WHAT COUNTRY <b>United States</b>			
13a. FATHER'S NAME <b>John E Sullivan</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Knox</b>				14. NAME OF HUSBAND OR WIFE <b>- - -</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>James D Sullivan</b>		Address <b>848 Renderer Dr. Woods</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b>										INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>170X</b>											
DUE TO (c)											
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 a.m. p.m.		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <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 <b>aug, 1961</b> to <b>Dec 29, 1962</b> and last saw her alive on <b>Dec 29, 1962</b> Death occurred at <b>5:00 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <b>S. H. Bondman M.D.</b>						22b. ADDRESS <b>9721 Manchester Rock Hill 19, Mo</b>				22c. DATE SIGNED <b>12-30-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>12-31-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Michael Cemetry</b>		23d. LOCATION (City, town, or county) <b>Springfield, Mass</b>		(State)			
24. FUNERAL DIRECTOR <b>Bopp Chapel 10610 Manchester Kirkwood</b>						25. DATE RECD. BY LOCAL REG. <b>DEC 31 1962</b>		26. REGISTRAR'S SIGNATURE <b>Loed Smith M.D.</b>			

USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert J. Lan Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 Mo.

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.