

JAN 25 1940

975

Primary Registration District No.

6020-a

86

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2
1
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bonne Terre, Mo.
(c) Name of hospital or institution: Bonne Terre Hospital
(d) Length of stay: In hospital or institution 1 day
In this community 1 years, months or days

8. (a) PRINT FULL NAME Samuel Frederick Sullivan

8. (b) If veteran, name war none 3. (c) Social Security No. -

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rena Sullivan 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Jan 7 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 8 If less than one day hr. min.

9. Birthplace Ballingen County, Mo.
(City, town or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Retired

12. Name George Sullivan

13. Birthplace Ballingen County, Mo.
(City, town or county) (State or foreign country)

14. Maiden name Kathie Reed

15. Birthplace Ballingen County, Mo.
(City, town or county) (State or foreign country)

16. (a) Informant J. W. Sullivan

(b) Address Bonne Terre, Mo.

17. (a) Burial (b) Date thereof 12-17-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre Cemetery

18. (a) Signature of funeral director Bertram Hugh

(b) Address Bonne Terre, Mo.

19. (a) Jan 17 1940 (b) H. W. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre
(d) Street No. 422 N. Jackson
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15th
year 1940 hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from 12-14- 1940, to 12-15- 1940;

that I last saw him alive on 12-15- 1940, and that death occurred on the date and hour stated above.

Immediate cause of death

Cardiac collapse

Due to Chronic myocarditis 20 yrs.

Due to Fractured l. femur 24 hrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 12-14-40

(c) Where did injury occur? Bonne Terre, St. Francois Co., Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

While at work? no (Specify type of place) (e) Means of injury fall on ice

23. Signature H. W. Roebber (M. D. or other) M.D.

Address Bonne Terre, Mo. Date signed 12/20/40

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.....

C. J. Claywell

Licensed Embalmer No.

3706

P. O. Address.....

Ann Arbor, Michigan

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, above space should be left blank.