

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D OCT 12 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

30420  
Do not use this space.

791  
1008

7857

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City St. Louis, Mo. (d) Street No. St. John's Hospital St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary O'Connor

(a) Residence, No. 809 Clarendon, Ave. St. 12 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John J. O'Connor

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 28, 1885

7. AGE YEARS 53 MONTHS 2 DAYS 8 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) May 1937  
 11. Total time (years) spent in this occupation 20 yrs.

12. BIRTHPLACE (CITY OR TOWN) Franklin, County  
 (STATE OR COUNTRY) Illinois

FATHER 13. NAME John Unknown  
 14. BIRTHPLACE (CITY OR TOWN) Franklin, County  
 (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Phoebe White  
 16. BIRTHPLACE (CITY OR TOWN) Franklin, County  
 (STATE OR COUNTRY) Illinois

17. INFORMANT John J. O'Connor  
 (ADDRESS) 809 Clarendon, Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE West Frankfort, Ill. Sept. 5/ 38

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe, Inc.  
 (ADDRESS) 429 N. Euclid Ave.

20. FILED J. D. Bradley  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 3, 1938

22. I HEREBY CERTIFY, That I attended deceased from June 25, 1938, to Sept. 3, 1938  
 I last saw her alive on Sept. 2, 1938. Death is said to have occurred on the date stated above, at 8:45 a.m.  
 The principal cause of death and related causes of importance were as follows:

Diabetes Mellitus  
 Date of onset  
 Other contributory causes of importance:  
Rt. side Popliteal aneurysm  
Thrombophlebitis rt. thigh  
Secondary aneurysm

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify None  
 (Signed) Thos. A. Dill, M. D.  
 (Address) 7346 A. Max Chester Maplewood, Mo.

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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

G. Sullivan

Licensed Embalmer No. 1122

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 this body is not embalmed, above space should be left blank.