

No. 2
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7-35
X2-492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **26738**
Registrar's No. **6634**

SEP 25 1940 791
Registration District No. **791**

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS**
(c) Name of hospital or institution: **CITY HOSPITAL #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **50 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JAMES O'LEARY**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **460**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **CATHERINE O'LEARY** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **UNKNOWN** **1871**
(Month) (Day) (Year)

8. AGE: Years **69** Months **UNKNOWN** Days _____ If less than one day hr. _____ min. _____

9. Birthplace **IRELAND**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business _____
MOTHER FATHER { 12. Name **JAMES O'LEARY**
13. Birthplace **IRELAND**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **IRELAND**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. CATHERINE O'LEARY**
(b) Address **3946 NATURAL BRIDGE AVE.**

17. (a) **BURIAL** (b) Date thereof **AUG. 5, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **CALVARY CEMETERY**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 LINDELL BLVD.**

19. (a) **AUG 4 1940** (b) **J. F. Proctor**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County _____
(c) City or town **ST. LOUIS** **35**
(If outside city or town limits, write "RURAL")
(d) Street No. **ST. FRANCIS HOTEL 607 CHEST. ST.**
(If rural, give location)

(e) If foreign born, how long in U.S.A. _____ years.
Medical Certification

20. DATE OF DEATH: Month **AUG.** day **2nd**
year **1940** hour **4** minute **15A.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized Peritonitis from ruptured peptic ulcer**

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
Duration _____
PHYSICIAN _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury **5**
23. Signature **Joseph M. Quinn** (M. D. or other)
Address **Deputy Coroner** Date signed _____

10 am

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.