

N. B.—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.

**1. PLACE OF DEATH:**  
 (a) County St. Louis  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: En Route to City Hospital #1 3  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Patrick A. O'Leary 460  
 3. (b) If veteran, name war World War 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased January 1 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
49 7 19 hr. \_\_\_\_\_ min.

9. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Unemployed

MOTHER FATHER { 12. Name Benjamin O'Leary  
 { 13. Birthplace Ireland 5  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name Mary Fleming  
 { 15. Birthplace Ireland 5  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jos. O'Leary  
 (b) Address 3500 Miami St

17. (a) Burial (b) Date thereof August 22 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Peetz Brothers  
 (b) Address 3029 Lafayette Ave

19. (a) AUG 21 1940 (b) J. B. Borchert  
(Date received by Registrar) (Registered Embalmer)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State 0 (b) County \_\_\_\_\_  
 (c) City or town St. Louis 25  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 112 1/2 N. 6th St  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month 19th day August  
 year 1940 hour 4:15 minute P. M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ventricular rupture,  
Myocardial Infarct; Chronic  
Myocarditis.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 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) \_\_\_\_\_  
 (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) (or) Means of injury  
 23. Signature Joseph M. Lueken (M. D. or other) \_\_\_\_\_  
 Address Deputy Coroner Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

**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 Paul J. Dennis

Licensed Embalmer No. 2245

P. O. Address St. Louis, 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 this body is not embalmed, above space should be left blank.**