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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13291

FILED MAY 13 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3721

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 Days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000

(c) City or town ST. LOUIS 176
(If outside city or town limits, write "RURAL")

(d) Street No. 3305 ARLINGTON
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rose O'Neil

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29, year 1941 hour 4:20 minute A. M.

21. I hereby certify that I attended the deceased from April 19, 1941 to April 29, 1941 that I last saw h. OF alive on April 29, 1941 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 6 - 1876
(Month) (Day) (Year)

Immediate cause of death _____

Gangrene of left leg.
Arteriosclerosis.
Acute Parotitis. (no mumps)

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Gangrene of left leg.
Amputation of left leg.
Arteriosclerosis.

8. AGE: Years Months Days If less than one day

69 5 22 hr. _____ min.

9. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business AT HOME

MOTHER FATHER

12. Name PHILLIP CORCORAN
13. Birthplace IRELAND
(City, town, or county) (State or foreign country)

14. Maiden name MARY FITZSIMONS
15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant John O'Neil
(b) Address 3305 Arlington Ave

17. (a) BURIAL (b) Date thereof 5-1-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Buller & Kelly
(b) Address 7267 North Bend

19. (a) APP 30 1941 (b) J. F. Bridgman
(Date received by registrar) (Registrar's signature)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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)

(a) Means of injury _____

23. Signature R. V. Mulligan (M. D. _____)
Address 1515 Lafayette Avenue Date signed 4/29/41

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 *Clement M. Meaurio*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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, fact should be so stated above.