S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1945

Registration District No. 377

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 0

Registrar's No. 2759

3538

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town CLAYTON (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 415 POLO DRIVE (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ST LOUIS 96

(c) City or town CLAYTON (If outside city or town limits, write "RURAL") 2

(d) Street No. 415 POLO DRIVE (If rural, give location) 3

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME ROBERT E. O'CONNOR

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE 0

6. (b) Name of husband or wife

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

7. Birth date of deceased JAN. (Month) 30th (Day) 1930 (Year)

8. AGE: Years 14 | Months 11 | Days 22 | If less than one day hr. min.

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

10. Usual occupation AT SCHOOL

11. Industry or business —

FATHER
12. Name JAMES J. O'CONNOR
13. Birthplace W. VIRGINIA 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name VERONICA KENNEDY
15. Birthplace Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant James J. O'Connor, Sr.

(b) Address 415 POLO DRIVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 11 1945 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM

18. (a) Signature of funeral director L. Mullen Und Co

(b) Address 5165 DELMAR BL.

19. (a) JAN 10 1945 (Date received by local registrar) (b) E. G. McGavean M.D. (Registrar's signature) Omd

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 8th year 1945 hour 6 minute 5 P.M.

21. I hereby certify that I attended the deceased from Mar 1, 1944, to Jan 8, 1945; that I last saw him alive on Jan 8, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia (lobar)	1 day
Due to Chronic nephritis —	
Due to 108	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature George Martin (M. D. or other)

Address 4903 Delmar Date signed

(Licensed Embalmer's Statement on Reverse Side)

4903 Wabash Rd
3 30 - 5 30

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 H. G. Farris

Licensed Embalmer No. 3384

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.