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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 29 1947

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40541

Primary Registration District No. 6076

Registrar's No. 2436

1. PLACE OF DEATH:

(a) County St. Louis Mo

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

(c) Name of hospital or institution: JEWISH SANATORIUM
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis Mo 17
(If outside city or town limits, write "RURAL")

(d) Street No. no permanent home 9
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME John O'Connor

3. (b) If veteran, name war No

3. (c) Social Security No. 498-09-8197

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 October (Month) 18 (Day) 1894 (Year)

8. AGE: 53 Years 53 | Months 1 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace St. Louis Mo (City, town, or county) 6 (State or foreign country)

10. Usual occupation Hotel Clerk

11. Industry or business .....

FATHER
12. Name Dont Know
13. Birthplace ..... (City, town, or county) Dont Know (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace ..... (City, town, or county) Dont Know (State or foreign country)

16. (a) Informant Mrs. Elizabeth Pollard,
(b) Address 1302 Laurel Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.
(b) Address 3320 N. Kingshighway Blvd.

19. (a) 11-24-47 (Date received local registrar) (b) Cecil J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21 year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 17, 1947, 19..., to November 21, 1947; that I last saw him alive on November 21, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Decompensation of heart

Due to chronic rheumatic stenosis of the aortic valves

Due to 920

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration: recurring attacks since 1944 unknown

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 Felix Simon (M. D. or other)

Address JEWISH SANATORIUM Date signed 11/24/47

(Licensed Embalmer's Statement on Reverse Side) ROBERTSON, MO.

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 Fred Frick

Licensed Embalmer No. 3186

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, fact should be so stated above.