

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived). If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 4208 GROVE ST. 0	
3. NAME OF DECEASED (Type or Print) a. (First) DANIEL b. (Middle) c. (Last) O'ROURKE		4. DATE OF DEATH (Month) (Day) (Year) June 28th, 1950	
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH ABOUT 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPHER		11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO. 0	
13a. FATHER'S NAME DANIEL O'ROURKE		14. NAME OF HUSBAND OR WIFE ETHEL O'ROURKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MARGARET RAPIEN 4246 ATHLONE AVE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pelvic Abscess ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Transurethral Resection (3) DUE TO (c) Carcinoma of Prostate. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 177X			
22. I hereby certify that I attended the deceased from 6/13/50, 19, to 6/28/50, 19, that I last saw the deceased alive on 6/24/50, 19, and that death occurred at 8:00pm m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Allen P. Chapel M.D.		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 6/28/50			
24a. BURIAL CREMATION REMOVAL (Specify) BURIAL		24b. DATE 7/1/50	
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.	
DATE REC'D BY LOCAL REG. JUN 29 1950		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE	

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Ben Hoffman

Licensed Embalmer No.

4366

P. O. Address

Howe, 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.