

FILED JAN 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42662**
11212

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY J		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo. b. COUNTY 2029	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (If this place) 1 day	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital		STREET ADDRESS (If rural, give location) 5435 Cologne	

3. NAME OF DECEASED (Type or Print) a. (First) ADA b. (Middle) May c. (Last) O'Connor			4. DATE OF DEATH (Month) (Day) (Year) 12/27/50		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED/NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 12/23/1883	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Hours 4 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? 4	
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13a. FATHER'S NAME don't know		13b. MOTHER'S MAIDEN NAME don't know		14. NAME OF HUSBAND OR WIFE Fergus O'Connor	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. F. O'Connor 5435 Cologne			
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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) Cerebral Hemorrhage + Diabetic Coma			INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis				
	DUE TO (c)				
	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		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 11 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 321X			
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22. I hereby certify that I attended the deceased from **Dec 26**, 1950, to **Dec 27**, 1950, that I last saw the deceased alive on **Dec 27**, 1950, and that death occurred at **3 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Melba B. Bawell, M.D.		23b. ADDRESS 6376 Clayton Rd		23c. DATE SIGNED 12/29/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/30/50	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo		
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DATE REC'D BY LOCAL REG. DEC 29 1950	REGISTRAR'S SIGNATURE J. B. Lester		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Geo. A. Howard 1619 So. Grand		
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.

Student Embalmer No.....

Signed.....

J. Wm. Bensky

Signed.....
Student Embalmer

Licensed Embalmer No..... *3653*

P. O. Address.....

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.