

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35808
3503

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 2002 Registrar's No. 3503

1. PLACE OF DEATH a. COUNTY St. Louis		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 University City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2199	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 4496 Maryland	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6904 Washington			

3. NAME OF DECEASED (Type or Print) a. (First) Eugenia	b. (Middle) O'Hallaron	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 7 1873	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 1 MRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank R. O'Neil	13b. MOTHER'S MAIDEN NAME Henrietta Peters	14. NAME OF HUSBAND OR WIFE Anthony A.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME F. O'Neil	ADDRESS 0'Hallaron 505 East Drive
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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		INTERVAL BETWEEN ONSET AND DEATH 6 hrs years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral aneurysm		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterial sclerosis		
DUE TO (c)		DUE TO (c) Malignant ex peritum skull 6 yrs	
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 334X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 12/5, 1941, to 10/24, 1951, that I last saw the deceased alive on 10/22, 1951, and that death occurred at 6:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS 2327 N. Knapptonway	23c. DATE SIGNED 10/25/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10.26/51	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 10-26-51	REGISTRAR'S SIGNATURE Herbert R. Donke	25. FUNERAL DIRECTOR'S SIGNATURE Charles F. Stuart	ADDRESS 1225 Union
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4496

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Clement M. Shaw

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.