

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36725**
Registrar's No. **9734**

FILED NOV 13 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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		c. CITY (If outside corporate limits, write RURAL and give township) 2063 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5555 Wabada		f. STREET ADDRESS (If rural, give location) 6 5555 Wabada	
3. NAME OF DECEASED a. (First) John b. (Middle) J. c. (Last) O'Neill		4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH About 1868
9. AGE (In years last birthday) 84		10. MONTHS 8	10. DAYS 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Patrick O'Neill	
13b. MOTHER'S MAIDEN NAME Ellen Gallagher		14. NAME OF HUSBAND OR WIFE Theresa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 489-20-7992	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Gertrude Duffy 5555 Wabada
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 EMBOLISM (obstructed left side of body) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) starting the underlying cause last. DUE TO (b) HYPERTENSION DUE TO (c) ATHEROSCLEROSIS II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 4 weeks		7 YEAR	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)	
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? 332X	
22. I hereby certify that I attended the deceased from Sept 24, 1952 to Oct 21, 1952 , that I last saw the deceased alive on Oct 18, 1952 , and that death occurred at 8:30 am. , from the causes and on the date stated above.			
23a. SIGNATURE (Name or Title) Joseph R. Muehle, M.D.		23b. ADDRESS 1303 N. Kingshighway	23c. DATE SIGNED 10/21/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE 10/24/52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. OCT 23 1952	REGISTRAR'S SIGNATURE J. C. Smith	GENERAL DIRECTOR'S SIGNATURE ADDRESS W. F. Stewart 1225 Union	

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 J. Wm Densley

Licensed Embalmer, No. 3653

P. O. Address M. L. in Me

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.