

STANDARD CERTIFICATE OF DEATH

State File No. **6634**BIRTH NO. **FILLED MAR 12 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1906**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 2147	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		e. STREET ADDRESS (If rural, give location) 14 5710 Itaska St.	
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) c. (Last) O'LEAR		4. DATE OF DEATH (Month) (Day) (Year) 2 27 54	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 23, 1908
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (City and State or Foreign Country) Lyra, Penn.
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown Stryanka		13b. MOTHER'S MAIDEN NAME Anna Unknown	14. NAME OF HUSBAND OR WIFE Joseph O'Lear
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph O'Lear 5710 Itaska St.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leiomyosarcomatosis of abdominal cavity		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 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? 197X	
22. I hereby certify that I attended the deceased from 6-15, 1953 , to 2-27, 1954 , that I last saw the deceased alive on 2-27, 1954 , and that death occurred at 4:30 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE Thomas E Finn		23b. ADDRESS 1325 So. Grand Ave.	23c. DATE SIGNED 2-27-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Mar. 2, 1954	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
DATE REC'D BY LOCAL REG. MAR 1 1954	REGISTRAR'S SIGNATURE Charles Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.	

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Richard W. Storrs*.....

Licensed Embalmer No. *400*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.