

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31304**
Registrar's No. **7722**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7722	
1. PLACE OF DEATH a. COUNTY - - - -				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Washington D.C. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (In this place) 3 yrs.		c. CITY OR TOWN _____		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital				STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) Marion		b. (Middle) V.		c. (Last) O'Neill		4. DATE OF DEATH (Month) (Day) (Year) 9 1 1955	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH 3/15/1900	
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months 5		IF UNDER 1 YEAR Days 16		IF UNDER 24 HRS. Hours Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edward J. O'Neill		13b. MOTHER'S MAIDEN NAME Mary Gavin		14. NAME OF HUSBAND OR WIFE - - - -			
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. 579-36-5635		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. John Driscoll 5621 Rhodes St. Louis Mo.			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Fracture of Right Femur, when she fell on porch Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Hard B-3, at State Hospital on July 28, 1955 II. OTHER SIGNIFICANT CONDITIONS Accident Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		21c. (CITY, TOWN, OR TOWNSHIP) St. Louis Mo (COUNTY) St. Louis (STATE) _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, or bldg., etc.) Shop		21c. (CITY, TOWN, OR TOWNSHIP) St. Louis Mo (COUNTY) St. Louis (STATE) _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 28 55 ? m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E 903.7			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.						23c. DATE SIGNED 9/2/55	
23a. SIGNATURE Joseph M. Tucker		23b. ADDRESS 1500 Clark		23c. DATE SIGNED 9/2/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/5/1955		24c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. SEP 2 1955		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 3840 Lindell Blvd.			

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

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(Licensed Embalmer's Statement on Reverse Side)

