Health, & Welfare Public Service

. 300
1-57

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33938
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8675

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY
b. CITY OR TOWN ST. LOUIS, MO. Inside Limits Yes [X] No [ ]	c. CITY OR TOWN ST.LOUIS Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSP. #1. Length of stay in 1b 25	d. STREET ADDRESS (If outside, give location) 2610A North 9th. Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
DORA	MAE	O'CONNOR	SEPT.13, 1957

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	12-24-1893	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Missouri	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Unknown	Unknown	Joseph M. O'Connor

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.	17. INFORMANT Address
No		Joseph M. O Connor, 2610 a N. 9th.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Diabetes mellitus.	16yrs.
DUE TO (c)	260 X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21: I attended the deceased from 9/1/57, to 9/13/57 and last saw her/him alive on 9/13/57

Death occurred at 1:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Jean C. Chapman M.D.	1515 LAFAYETTE AVE.	9/16/57

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR ~~CREMATORY~~	23d. LOCATION (City, town, or county) (State)
Removal	9-16-1957	St.Trinity Luthern	St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
McLAUGHLIN'S, 2301 Lafayette	SEP 16 57	J Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 James R. Chapman

Licensed Embalmer No. 4550

P. O. Address St. Louis, Mo.

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.