MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35781

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 10582

City St Louis (No. 4149 St Louis a St. ..... Ward)

2. FULL NAME Thomas J O'Fallon

(a) Residence. No. ..... St., 10 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mabel O'Fallon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 7th 1885

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	44	0	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe maker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis

PARENTS

10. NAME OF FATHER Patrick O'Fallon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis

12. MAIDEN NAME OF MOTHER Ellen Mullen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis

14. INFORMANT Mrs Mable O'Fallon
(Address) 4149 St Louis a

15. FILED OCT 28 1929, 19.. Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/26 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1929, to Oct 26th 1929, that I last saw him alive on 3 am 10/26 1929, and that death occurred, on the date stated above, at 8 36 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Myocarditis Chronic
131
93C
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Influenza 1915
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

1290

(Signed) Frank Bergher M.D.
12/26, 1929 (Address) 6200 Pershing

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary	10-29 1929
20. UNDERTAKER	**ADDRESS**
Arthur J Donnelly	2039 Wash St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INKLETTING IS A PERMANENT RECORD

Dr Boughan
6200 Pershing
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