

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No. City)

Registration District No. 791
Primary Registration District No. 1003

File No. 28003
Registered No. 7832
St. Ward

2. FULL NAME

John O'Fallon

(a) Residence. No. 2442 N. G. Harrison St., 20 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 single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abn 54 - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Sewer Dept
(c) Name of employer

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

10. NAME OF FATHER Patrick O'Fallon
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Bridget Gallagher
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Mrs. M. Mulleady
(Address) 4557 Alcott Ave

15. FILED Aug - 6 1931 May C. Turley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 1930

17. No Physician attended
I HEREBY CERTIFY, That I attended deceased from, 19..... to, 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 10:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Surgery
(Household Churn)
St. Louis Mo.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED Accident

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. Keene M.D.
1930 (Address) St. Louis Mo.

*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 Calvary DATE OF BURIAL 8-6 1930
20. UNDERTAKER Arthur J. O'Smelly ADDRESS 2039 Wash St

K. 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City St. Louis (No.)

Registration District No. 791
Primary Registration District No. 1003

File No. ~~28004~~
Registered No. 7832
St. Ward

2. FULL NAME John O'Fallon

(a) Residence, No. St., 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. FILED 19..... Max b. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 19 30

17. I HEREBY CERTIFY, That I attended deceased from
19..... to 19.....
that I last saw h..... alive on..... 19....., and that
death occurred on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & injuries
caused by auto
crushed chest
struck by auto
(duration) yrs. mos. ds.

CONTRIBUTORY was walking in street
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-28013