

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

Do not use this space.

23417

**1. PLACE OF DEATH**

County..... Registration District No. F 101  
 Townshp..... Primary Registration District No. 7002  
 City St. Louis Mo. (No. St. Anthony Hospital) St. 6913 Ward

**2. FULL NAME** Miss Margaret O. Connor  
 (a) Residence, No. 3520 Chippewa St. 16 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** Female  
**4. COLOR OR RACE** White  
**5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single  
 (write the word)  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Jan 8 - 1893  
**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
38 5 15  
**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work. None Invalid  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

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

**10. NAME OF FATHER** Michael O'Connor  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** Ireland  
 (STATE OR COUNTRY)  
**12. MAIDEN NAME OF MOTHER** Mary Mulvaney  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** Ireland  
 (STATE OR COUNTRY)

**14. INFORMANT** Cathrine O'Connor  
 (Address) 4340 Olive St.

**15. FILED** IN 20 19 1931  
May O'Starkley  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** June 23 1931  
**17. I HEREBY CERTIFY, That I attended deceased from** June 22, 1931, to June 23, 1931, that I last saw h. er alive on June 22, 1931, and that death occurred, on the date stated above, at 5 A. m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumo pneumonia (acute)  
93C  
107A  
97 (duration) ..... yrs. ..... mos. 3 ds.  
 CONTRIBUTORY (PRIMARY) Arteriosclerosis (General)  
 (SECONDARY) Myocarditis Chronic (duration) ..... yrs. ..... mos. ..... ds.

**18. WHERE WAS DISEASE CONTRACTED** At home  
 (NOT AT PLACE OF DEATH)  
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb 17, 1931  
 WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam. Laboratory  
 (Signed) Robert France M. D.  
June 23 1931 (Address) 525 Franco Bldg

\*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** St. Peter & Paul Cemetery DATE OF BURIAL June 24 1931

**20. UNDERTAKER** J. H. Kubken & Co ADDRESS 2842 Sprance

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

