

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

Do not use this space.

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1123 File No. 19054  
 Township Cassville Primary Registration District No. 624803 Registered No. 1370  
 City Jefferson Barracks, Mo. Veterans' Administration Facility St. \_\_\_\_\_ Ward)

**2. FULL NAME** William O'DONNELL

(a) Residence, No. 7230 So. Levee, St. Louis, Mo. 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**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14 1934

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

22. I HEREBY CERTIFY, That I attended deceased from February 11 1934 to May 14 1934

I last saw him alive on May 14 1934 Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 12, 1867

to have occurred on the date stated above, at 10: P. M.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 67 1 2

The principal cause of death and related causes of importance were as follows:

Infective thrombo phlebitis Date of onset Unkn.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Butcher

97  
99B  
100A/100A

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Swift Packing Co.

10. Date deceased last worked at this occupation (month and year) Unavailable 11. Total time (years) spent in this occupation Unavailable

Other contributory causes of importance:  
Abscess of left lung- Arterio-sclerosis and thrombo angitis, obliterans Unkn.  
Amputation of right leg/

12. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

13. NAME William O'Donnell

Name of operation Amputation of right leg/ Date of May 4/34  
 History, physical exam., X-Ray and What test confirmed diagnosis? Laboratory findings

14. BIRTHPLACE (CITY OR TOWN) Unavailable (STATE OR COUNTRY) Unavailable

15. MAIDEN NAME Eulila Chouquett

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) Unavailable (STATE OR COUNTRY) Illinois

17. INFORMANT E. T. Gallagher, M.D., Att. Gen. Dir. (ADDRESS) Vets. Adm. Fac., Jeff. Bks., Mo.

Manner of injury \_\_\_\_\_ Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE National Cem. Jeff. Bks. Mo. DATE May 17 1934

19. UNDERTAKER Mullen Bros (ADDRESS) 42542 Industrial Blvd

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_ If so, specify \_\_\_\_\_

20. FILED B-15 1934 Q4411C-1001 Registered

(Signed) W. GIBSON, M.D., Manager M.B.  
 (Address) Vets. Adm. Fac., Jeff. Bks., Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

JUN 26 1934

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Jefferson Bks.

WASHINGTON

19054

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Wm O'Donnell  
Who died at Vets Adms Facility on May 14 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex M Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 67 Months \_\_\_\_\_ Days 2

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: Cause of amputation of leg. by gangrene

Other contributory causes of importance: absence of rest during non-tubercular cause mixed infection

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

Signature of Registrar E. J. Mc Gaugh M.D.

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 1123 Very truly yours,

Primary Reg. Dist. No. 6248B E. J. Mc Gaugh M.D.

Special Agent.