

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.

AUG 21 1934

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

Do not use this space.

1. PLACE OF DEATH  
 County Jackson Registration District No. 300  
 Township Lead Primary Registration District No. 100  
 City Kansas City (No. 12C General Hosp) St. Dist Ward 11  
 File No. 24458  
 Registered No. 5271  
 2. FULL NAME E. J. O'Connell  
 (a) Residence, No. 1212 W 20th St., \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) \_\_\_\_\_  
 Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14 - 1885  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
49 | 1 | 26  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NY  
 MOTHER  
 13. NAME Pat O'Connell  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland  
 FATHER  
 15. MAIDEN NAME Kath. Walsh  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland  
 17. INFORMANT (ADDRESS) General Hospital #2  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19\_\_\_\_  
St. Mary's July 14 1934  
 19. UNDERTAKER (ADDRESS) 750 Broadway  
 20. FILED July 16 1934 M. M. W. Brown Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-10 1934  
 22. I HEREBY CERTIFY, That I attended deceased from 6-27 1934 to 7-10 1934  
 Last saw him alive on 7-10 1934 Death is said to have occurred on the date stated above, at 10:08 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis Date of onset 2/27  
 Other contributory causes of importance: 2/3  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 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. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) P. F. De Maria M. D.  
 (Address) Asst. Supt. 12C Gen. Hosp

