

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.

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

Do not use this space.

1. PLACE OF DEATH *SEP 23 1934*  
 County..... Registration District No. *791*  
 Township..... Primary Registration District No. *1003*  
 City..... *St Louis* (No. *De Paul Hospital*)..... St. *1* Ward) *31101*  
 2. FULL NAME *Les a O'Connell*  
 (a) Residence, No. *7277 Roland St.* Ward. *NR*  
 (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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Rosalie O'Connell*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown 1888*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*46*  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc. *Painting*  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Contractor*  
 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) *St Louis*  
 MOTHER FATHER  
 13. NAME *John W. O'Connell*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*  
 15. MAIDEN NAME *Ann Nolan*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St Louis*  
 17. INFORMANT *Rosalie O'Connell*  
 (ADDRESS) *7277 Roland St.*  
 18. BURIAL, CREMATION, OR REMOVAL  
 PLACE *Cabrany* DATE *8-18-* 1934  
 19. UNDERTAKER *Arthur J. Wornell & Co.*  
 (ADDRESS) *3849 Lafayette St.*  
 20. FILED *AGG 10 1934*  
*J. Brebeck*  
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *August 15, 1934*  
 22. I HEREBY CERTIFY, That I attended deceased from *August 14, 1934, to August 15, 1934*  
 I last saw him alive on *August 15, 1934*. Death is said to have occurred on the date stated above, at *5 P.* m.  
 The principal cause of death and related causes of importance were as follows:  
*9A.P. Angina Pectoris*  
*15/103*  
*AWA*  
 Other contributory causes of importance:  
*Coronary pneumonia*  
 Date of onset *8/14/34*  
 Name of operation *None* Date of.....  
 What test confirmed diagnosis *Electrocardiogram* Was there an autopsy? *No.*  
 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? *No.*  
 If so, specify.....  
 (Signed) *Bernard T. Keon* M. D.  
 (Address) *7264 Natural Bridge Road*

Wd 15th and 1205m

7064 N Bridge

Ev 4880

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