

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.

OCT 14 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32251

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **3929 McPherson Ave.** Registered No. **8305**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mary M. O'Connor
 (a) Residence, No. **3929 McPherson Ave.** St. **19**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 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) **March 12, 1874**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
63 5 20
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**
 9. Industry or business in which work was done, as 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) **Indianapolis** (STATE OR COUNTRY) **Ind.**

FATHER 13. NAME **Joseph O'Connor**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

MOTHER 15. MAIDEN NAME **Margaret McQuade**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT **Miss Anna A. O'Connor** (ADDRESS) **3929 McPherson Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem.** DATE **Sept. 4, 1937**

19. FUNERAL DIRECTOR **Arthur J. Donnelly Undt.** (ADDRESS) **3840 Lindell Blvd.**

20. FILED **SEP 3 1937** **J. T. Bredeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 2nd 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Sept. 1**, 19**37**, to **Sept. 2**, 19**37**.
 I last saw her alive on **Sept. 2**, 19**37**. Death is said to have occurred on the date stated above, at **9:50 a.m.**
 The principal cause of death and related causes of importance were as follows:

Angina pectoris
OK

Other contributory causes of importance: **Arteriosclerosis**

Name of operation Date of
 What test confirmed diagnosis? **B.P. 160** 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**
 (Signed) **J. T. Bredeck** (Address) **210 Theatre Bldg.**, M. D.

STATEMENT BY LICENSED EMBALMER

I, W.H. Van Matre, Licensed Embalmer No. 2825

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed W.H. Van Matre

Licensed Embalmer No. 2825

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)