

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

32697

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. **De Paul Hosp.** St.
 (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 **55** yrs. mos. ds. (f) How long in U. S., if of foreign birth? **55** yrs. mos. ds.

2. PRINT FULL NAME **John O'Gara**

(a) Residence, No. **2152 E. Warne Ave.** St. **9** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) 6/22/1854		
7. AGE YEARS 83	MONTHS 2	DAY 26
If LESS than 1 day, ... hrs. or min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Clerk.		
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) (STATE OR COUNTRY) Ireland		
13. NAME Michael O'Gara		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland		
15. MAIDEN NAME Rose Noon		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland		
17. INFORMANT (ADDRESS) Michael O'Gara 2152 E. Warne Ave.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 9/20/37		
19. FUNERAL DIRECTOR (ADDRESS) W. A. Stock Uni. Co. 2117 E. Grant Blvd.		
20. FILED SEP 10 1937 J. Biedeck Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9/18/37**

22. I HEREBY CERTIFY, That I attended deceased from **June 1**, 19**37**, to **9/18**, 19**37**.

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at **12:30 A.M.**

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

Chronic Myocarditis Date of onset **1936**

Other contributory causes of importance:

Interosclerosis **1930**

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? **Yes**

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) **Ross W. Medley** M. D.
 (Address) **414 W. 7th St. St. Louis**

174
404 W. Flinders
Q.S. 2783

STATEMENT BY LICENSED EMBALMER

Frank A. Moore....., Licensed Embalmer No. 3041

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 Frank A. Moore
Licensed Embalmer No. 3041

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.)