

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

36202
Do not use this space.

1. PLACE OF DEATH **NOV 15 1937**
 (a) County _____ Registration District No. **20 791**
 (b) Township _____ Primary Registration District No. **1003** Registered No. **9779**
 (c) City **ST. LOUIS MO.** (d) Street No. **3123 EADS AV.** _____ 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **JOSEPHINE O'CONNOR.**
 (a) Residence, No. **3123 EADS AV.** St. **17** (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 **FEMALE**
 4. COLOR OR RACE **WHITE**
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **WIDOW**
 5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF **CORNELIUS O'CONNOR.**
 (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **APRIL 1, 1876**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 6 18
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. **HOUSEKEEPER**
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **OCT. 19 1937**
 22. I HEREBY CERTIFY, That I attended deceased from **Oct 3rd**, 1937, to **Oct 19**, 1937
 I last saw her alive on **Oct 19 AM**, 1937. Death is said to have occurred on the date stated above, at **12:30 pm**.
 The principal cause of death and related causes of importance were as follows:

Arteriosclerosis
1246
 Date of onset **About Oct 37**
 Other contributory causes of importance:
Chronic hypertension with stroke
Deterioration

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND.**
 13. NAME **BARTH LAWLOR**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**
 15. MAIDEN NAME **NELLIE O'NEIL.**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**
 17. INFORMANT (ADDRESS) **BARTH O'CONNOR 3123 EADS AV.**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY CEM.** DATE **Oct. 23 1937**
 19. FUNERAL DIRECTOR (ADDRESS) **E. J. Schuur 3125 Lafayette**
 20. FILED **OCT 21 1937** **J. Bredeck** Local Registrar.

Name of operation **none** Date of **none**
 What test confirmed diagnosis **Physiase** Was there an autopsy **no**
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **no** Date of injury **none**, 1937
 Where did injury occur? **none** (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. **none**
 Manner of injury **none**
 Nature of injury **none**
 24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify **no**
 (Signed) **E. J. Schuur**, M. D.
 (Address) **1505 So. Jefferson Ave.**
St. Louis, Mo.

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.

STATEMENT BY LICENSED EMBALMER

I, James G Sullivan, Licensed Embalmer No. 2260
hereby certify that the body recorded on the reverse side of this certificate was embalmed by James G Sullivan
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed James G Sullivan
Licensed Embalmer No. 2260

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.)