NOV 17 1937

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

Do not use this space.

37728

File No. 962

Registered No.

1. PLACE OF DEATH
County Greene — Registration District No. 318
Township Campbell — Primary Registration District No. 540
City ~~Springfield~~ (No. 1 U.S. Federal Hospital St. Ward)

2. FULL NAME O'HARE, Patrick

(a) Residence, No. St., Ward. Kaywood, Ohio
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Voilet O'Hare

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-17-80

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
57	57	6	17	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
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) DK
11. Total time (years) spent in this occupation DK

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

FATHER
13. NAME DK
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
15. MAIDEN NAME DK
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Deceased

18. BURIAL, CREMATION, OR REMOVAL
PLACE Springfield, Mo DATE 10-8-37, 19

19. UNDERTAKER Alma Lohmeyer Funeral Home
(ADDRESS) Springfield, Missouri

20. FILED Oct 8, 19 37 Chas A Thomas M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 4, 1937, 19

22. I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1934, 19 to Oct. 4, 1937, 19
I last saw him alive on Oct. 4, 1937, 19 Death is said to have occurred on the date stated above, at 4:05 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cellulitis of the Omentum and Transverse Colon	

Other contributory causes of importance:
Hemorrhage of left Adrenal Gland

Name of operation Enteroplasty Date of 10-1-37
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? No
If so, specify
(Signed) T. H. Smith, A. A. Surgeon, M. D.
(Address) Clinical Director, USHDD, Springfield, Missouri.

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.

152

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

37728
Do not use this space.

1. PLACE OF DEATH
(a) County Greene — Registration District No. 318
(b) Township Campbell — Primary Registration District No. 5440 — Registered No.
(c) City — (d) Street No. — 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 O'Hare Patrick
(a) Residence, No. — St. (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
m	W	Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
57	6	17	

OCCUPATION
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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED — 19 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 4, 1937

22. I HEREBY CERTIFY, That I attended deceased from — 19 — to — 19
I last saw h — alive on — 19 — Death is said to have occurred on the date stated above, at — m.
The principal cause of death and related causes of importance were as follows:

Cellulitis of the omentum and transverse colon — Date of onset

Other contributory causes of importance:
Hemorrhage of left adrenal gland (autopsy showed no evidence of tuberculosis)

Name of operation Microplast — Date of 10-1-37
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) T. H. Smith, M. D.
(Address) Clinical Director USPHDD Springfield Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.