

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  
STANDARD CERTIFICATE OF DEATH

40846

Registration District No. 5584

Primary Registration District No. 111

State File No. \_\_\_\_\_

Registrar's No. 2108

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Richmond Heights  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Mary's Hosp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town High Ridge  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Margaret O'Connor 256  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, Married  
 6. (b) Name of husband or wife Bernard W. O'Connor 6. (c) Age of husband or wife if alive 36 years  
 7. Birth date of deceased March 10, 1904  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov. day 29  
 year 1939 hour 10 minute 10 P. M.  
 21. I hereby certify that I attended the deceased from 11/29 11/16/39 to 11/29 11/29, 1939  
 that I last saw her alive on 11/29 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
35 8 19 hr. min.

Immediate cause of death Mesmeric  
 Due to Chronic Glomerulonephritis  
 Due to \_\_\_\_\_  
 Other conditions Edema of viscera & lymphatic glands.  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy Chronic Glomerulonephritis

9. Birthplace Butler, Missouri  
 (City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically  
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10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name James Porter  
 13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Myrtle Haynes  
 (City, town, or county) (State or foreign country)  
 15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Porter  
 (b) Address 7544 Folk Ave.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

17. (a) Burial (b) Date thereof Dec. 2, 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address 7456 Manchester

While at work? \_\_\_\_\_ (Specify type of place)  
 Means of injury \_\_\_\_\_  
 19. (a) DEC 1 1939 (b) \_\_\_\_\_ (M. D. of other)  
 (Date received local registrar) (Registrar's signature) Address Rushwood, Mo Date signed 12/1/39

20288

APR 30 1948

MAK 28 1348

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4029

P. O. Address..... Maplewood

**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.)**

**If this body is not embalmed, above space should be left blank.**