DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4916

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1746

1. PLACE OF DEATH:
(a) County: St. Louis.
(b) City or town: St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Infirmary.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution February 15, 1940 (Specify whether
In this community 25yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: St. Louis.
(c) City or town: St. Louis.
(If outside city or town limits, write "RURAL")
(d) Street No.: 5800 Arsenal St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? American. years.

3. (a) PRINT FULL NAME: Thomas O'Donnell,

3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mary O'Donnell
6. (c) Age of husband or wife if alive: 23 years
7. Birth date of deceased: May (Month) (Day) 1889 (Year)

8. AGE: Years 50 Months 8 Days 24 If less than one day hr. min.

9. Birthplace: Canton, Ohio. (City, town, or county) (State or foreign country)
10. Usual occupation: Carpenter.
11. Industry or business: X

FATHER
12. Name: Thomas O'Donnell
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Lena Ackins (deceased)
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: E. Mulony
(b) Address: 5800 Arsenal St.
17. (a) (Burial, cremation, or removal) (b) Date thereof: 2/2/40 (Month) (Day) (Year)
(c) Place: burial or cremation: CALVARY
18. (a) Signature of funeral director: Cullen & Kelly
(b) Address: 1416 N Taylor Ave
19. (a) FEB 20 1940 (Date received local registrar) (b) J. F. Bacharach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February Day 17, year 1940 hour 11:15 minute a. M.

21. I hereby certify that I attended the deceased from February 15, 1940 to February 17, 1940 that I last saw him alive on February 17, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Cardiac Failure	
Carcinomatosis c primary	
Site at head of Pancreas. ~~Primary~~	
Due to: Lobar Pneumonia	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations:

Of autopsy: Carcinomatosis c primary site Head of Pancreas. Lobar Pneumonia.

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): No
(b) Date of occurrence:
(c) Where did injury occur? No (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work?
(e) Means of injury:

23. Signature: Geo. S. Bryan (M. D. or other)
Address: Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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.

WHITE PAPER—USE WITHOUT BLUE LINES

1 X19511

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~~ Raymond E. Gehrke, ~~Registered Apprentice No.~~ working under my personal supervision.

City license #180

Signed Raymond E. Gehrke

Licensed Embalmer No. 3985

P. O. Address St Louis, Mo

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

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