

No. 2  
FILED  
MAY 15 1940  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **13181**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **3383**

**1. PLACE OF DEATH:**

(a) County.....

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
City Hospital #1 /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 Hrs.  
(Specify whether)

In this community 3 yrs.  
years, months or days

8. (a) PRINT FULL NAME Fannie O'Connors 256

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife J. P. O'Connors

6. (c) Age of husband or wife if alive Nil years

7. Birth date of deceased Oct. 22 1872  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
67	5	21	hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER

12. Name Joe Tominson

13. Birthplace Moberly Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Isabel McCloofion

15. Birthplace N. Salem Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Olivia Bignas

(b) Address Brookfield, Mo

17. (a) Burial 1 (b) Date thereof Apr. 19 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Mo.

18. (a) Signature of funeral director Cluedman Gona

(b) Address 3934 W. 20th St.

19. (a) APR 14 1940 (b) J. J. [Signature]  
(Date received local registrar) (Signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County.....

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 824 Grape  
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 13  
year 1940 hour 8 minute 55 A. M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death Acute hemorrhagic purpura  
epidemic typhus

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Other findings: Of operations.....

Of autopsy As above

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).....

(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?.....

While at work?..... (Specify type of place) (Means of injury)

23. Signature [Signature] (M. D. or other).....

Address City Hospital Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 Alfred J. Broecker

Licensed Embalmer No. 2663

P. O. Address 4204 Paine

**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.**