

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

16719
State File No. _____
Registrar's No. **4197**

Registration District No. **791**

Primary Registration District No. _____

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: **DePaul Hospital**
(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

3. (a) PRINT FULL NAME **Timothy O'Connell 254**

8. (b) If veteran, name war _____
3. (c) Social Security No. **493-09-4123**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 3 1894**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 0 5 hr. min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Telegraph Operator**

11. Industry or business **Mc. Quay-Norris Co.**

12. Name **Timothy O'Connell**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Murphy**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (e) Informant **Mrs Nellie Teckner**

(b) Address **4060 Burgen Ave**

17. (a) **Burial** (b) Date thereof **5-11-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**
Cullinane Bros.

18. (e) Signature of funeral director _____
(b) Address **1710 N. Grand Blvd.**
MAY 10 1940
19. (a) _____ (b) **J. J. Brudick**
(Date received local registrar) (Registrar's 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. **4061 Burgen Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **8**
year **1940** hour **11** minute **0** a. M.

21. I hereby certify that I attended the deceased from **May 4**, 19 **40**, to **May 8**, 19 **40**,
that I last saw him alive on **May 4**, 19 **40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary vascular**
renal disease with
hypertension
Duration **3 years**

Due to _____
Due to _____

Other conditions **Congenital malformation**
(Include pregnancy within 3 months of death)
of spine (kyphosis)

Major findings: _____
Of operations: _____
Of autopsy: _____

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) _____
(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?

(Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature **Thomas Lane** (M. D. or other) _____
Address **1117 N Grand** Date signed **May 8/40**

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

0800 1.0

0100 1.0

0000 1.0

0000 1.0

0000 1.0

0000 1.0

Handwritten notes:
Fred Truck
3186
St. Louis, Mo

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 *Fred Truck*

Licensed Embalmer No. *3186*
P. O. Address *St. Louis, Mo*

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.