

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
112 1/2 N. Sixth St.  
 (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

8. (a) PRINT FULL NAME John O'Mail

8. (b) If veteran, name was no 8. (c) Social Security No. none

4. Sex Male 5. Color or race Wh  
 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 Feb. 12 1974  
 (Month) (Day) (Year)

8. AGE: Years 64 Months 10 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Barkeeper Tavern

11. Industry or business WPA workary

12. Name John O'Mail

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

14. Maiden name Ann O'Halloran

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

16. (a) Informant Ann Ellison

(b) Address 5712 Cote Brillante

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24  
 (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles

18. (a) Signature of funeral director John T. Moran

(b) 1225 N. 1st  
 19. (a) Date received local registrar DEC 31 1940 Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 6  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5712 Cote Brillante Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH; Month December day 30  
 year 1940 hour 7 minute -A. M.

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

Immediate cause of death Ulcerative aortitis  
and non-reveral  
Coronary sclerosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations gdt  
 Of autopsy \_\_\_\_\_

Duration

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?

While at work? \_\_\_\_\_ (Specify type of place)  
 by means of injury \_\_\_\_\_

23. Signature W. H. Terry (M. D. or other)  
 Address St. Charles Date signed 12/31/40

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

MOTHER FATHER

**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 *Bernard A. J. Stuart*  
Licensed Embalmer No. *3500*  
P. O. Address *1225 Union, Pa*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41134  
Registrar's No. 10900

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 112 1/2 N. 1st St  
(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 John W. Neill  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race white 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 66 Months 10 Days 18 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-14-41 (b) J. F. Bredek (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Alfred Perry (Physician's signature)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

S-41134

1960