

FILED JAN 4 1944 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

11636

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:
5133 PAGE BLV. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000
(c) City or town ST. LOUIS 12
(If outside city or town limits, write "RURAL") 922
(d) Street No. 2622 PARK AV
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME DELIA O'NEILL

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

4. FEMALE 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 FEB. 22 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 1 If less than one day hr. min.

9. Birthplace IRELAND 4
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

11. Industry or business

MOTHER FATHER { 12. Name PATRICK
13. Birthplace IRELAND 4
(City, town, or county) (State or foreign country)
14. Maiden name ROSE SHAY
15. Birthplace IRELAND 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Annie Proctor

(b) Address 5133 Page Blv.

17. (a) BURIAL (b) Date thereof DEC 27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schuur

(b) Address 3125 Lafayette Av

19. (a) DEC 24 1943 (b) Registrar's signature J. F. [Signature]
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23
year 1943 hour 11 minute 45 A. 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 Lobar Pneumonia

Due to 108

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

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

Date signed 12/24/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Joe B Vollmer*.....

Licensed Embalmer No. *40-14*.....

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, fact should be so stated above.