

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County ST LOUIS MO  
(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: 5651 MAFFITT AVE 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution 75 YEARS (Specify whether  
in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME JAMES J. OCONNOR

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ANNA OCONNOR 6. (c) Age of husband or wife if alive DEAD years

7. Birth date of deceased OCT 20 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 13 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace NEW YORK CITY (City, town, or county) (State or foreign country)

10. Usual occupation CITY FIREMAN

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

MOTHER FATHER { 12. Name JOHN OCONNOR  
13. Birthplace IRELAND (City, town, or county) (State or foreign country)  
14. Maiden name BRIDGET DENT  
15. Birthplace IRELAND (City, town, or county) (State or foreign country)

16. (a) Informant MISS ECELIA OCONNOR

(b) Address 5651 MAFFITT AVE.

17. (a) BURIAL (b) Date thereof APRIL 5 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: CALVARY CEMETERY

18. (a) Signature of funeral director JOS. A. HOWARD

(b) Address 1619 S GRAND BLVD.

19. (a) APR 4 1945 (b) J. F. Bernebeck  
(Date received local registrar) (Registrar's signature)

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. 5651 MAFFITT AVE (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2 year 1945 hour 2 minute 10 a. M.

21. I hereby certify that I attended the deceased from Oct 23, 1945 to April 2, 1945  
that I last saw him alive on April 1, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease Duration \_\_\_\_\_

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

Due to 4th \_\_\_\_\_

Other conditions Carcinoma of rectum  
(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 J. F. Bernebeck (M. D. or other) M.D.  
Address 3720 Washington Date signed 4/13/45

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

*Gas A. Howard*

Licensed Embalmer No. *4139*

P. O. Address. *4212 St Louis Ave*

**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.**