

FILED MAR 16 1945

2061

Registration District No. _____

Primary Registration District No. _____

100

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:
3425 N. 14 Th Str /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 years, months or days)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME Maureen O'Hara8. (b) If veteran,
name war _____8. (c) Social Security
No. _____4. Sex. Female 5. Color or
race White 6. (a) Single, widowed, married,
Child divorced6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased Aug. 31 1944
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
6 -- 2 -- hr. min.9. Birthplace St Louis MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Walter O'Hara13. Birthplace Allabama
(City, town, or county) (State or foreign country)14. Maiden name Adel Neenan15. Birthplace St Louis
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Walter O'Hara(b) Address 3425 N 14 Th 194517. (a) Burial (b) Date thereof March 3 D
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Calvary Cem.18. (a) Signature of funeral director Edward Koel(b) Address 3516 N 14 Th Str19. (a) MAR 3 1945 (Date received local Registrar's signature) J. F. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
 (c) City or town St Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3425 N 14 Th Str /
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 2nd
year 1945 hour 12 minute 30 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 Primary

Due to _____

Other conditions
(Include pregnancy within 3 months of death) 100%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 [Signature] (M. D. or other)
Address [Signature] Date signed 3/3/45

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.

No. Embalming

Signed *Edw Koch funeral Director*

Licensed Embalmer No.....

P. O. Address.....

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.