S. No. 2
M—5-43
7. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11622

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3437

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 Hosp 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 090 17 6 11

(c) City or town St.Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3618 St.LOuis Ave
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William(Gary) O'Connell

3. (b) If veteran, name war NONE

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Grace

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased July 6th. 1894 (Month) (Day) (Year)

8. AGE: Years 50 Months 9 Days 10 If less than one day hr. min.

9. Birthplace St.Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Salesman

11. Industry or business

FATHER
12. Name William O'Connell
13. Birthplace St.Louis (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Anna Sweeney
15. Birthplace (City, town, or county) Conn 1 (State or foreign country)

16. (a) Informant Mrs Grace O'Connell
(b) Address 3618 St.Louis Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheahan Und Co
(b) Address 4415 Washington Blvd.

19. (a) APR 18 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th. year 1945 hour P.M. minute M.

21. I hereby certify that I attended the deceased from Jan 4, 1945 to April 16, 1945 that I last saw him alive on April 16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial damage due to coronary occlusion	11 mo
Due to: Cause unknown	
Due to: 94a	
Other conditions (Include pregnancy within 3 months of death): Prostatic hyper trophy	2 yrs

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) N
(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 R Emmet Ham (M. D. ~~or other~~)
Address 1117 N Grand Date signed Apr 17/45

(Licensed Embalmer's Statement on Reverse Side)

Dr Bennett Kane
Grant & Cook

Will call later

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 Albert G. Kappe

Licensed Embalmer No. 2971

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, fact should be so stated above.