

S. No. 2
M-543
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25578

State File No. _____
Registrar's No. **6699**

FILED AUG 9 1946
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
Enrout City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **48 Yrs. 11 Mons 26 Days** (Specify whether years, months or days)

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. **2830 N Jefferson Ave**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William J O'Conner**
(b) If veteran, name war **no**
(c) Social Security No. **488-05-9515**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **29**
year **1946** hour **7.15** minute **00** 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.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Angela O'Conner**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **8 3 1897**
(Month) (Day) (Year)

Immediate cause of death **Chronic Endocarditis
Chronic Hypertrophic Myocarditis**
Due to _____
Due to **9 2**
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
48 11 26 hr. _____ min.

9. Birthplace **New Albany Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Metal Worker**

11. Industry or business _____

MOTHER FATHER { 12. Name **Wm. H. O'Conner**
13. Birthplace **Louisville Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Doherty**
15. Birthplace **New Albany Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edward Becker**
(b) Address **3520 N 23 St.**

17. (a) **Burial** (b) Date thereof **8-1-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Donald J. Goodhart**
(b) Address **2228 St. Louis Ave**

19. (a) **JUL 31 1946**
(Date received local registrar) (Registrar's signature)

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?

(Specify type of place) _____
(e) Means of injury _____
23. Signature **Alfred J. Brown** (M. D. or other) **3**
Address _____ Date signed **7/31/46**

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 Mapie A. Cashion
Licensed Embalmer No. 3949
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.