

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

36121

State File No.

FILED NOV 14 1947

318

Primary Registration District No.

1003

Registrar's No. 10188

1. PLACE OF DEATH:

(a) County.....

(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:
Pronounced dead at City Hospital 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether)

In this community.....
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County..... 000

(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL"..... 17)

(d) Street No. 5-91. 97th St - STAG Pacific? HOTEL
25 (If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME JOHN W. O'HEREN

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex MALE race W. 5. Color or

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 APRIL 13- 1866
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|----------|----------------------|
| <u>81</u> | <u>6</u> | <u>2</u> | br. min. |

9. Birthplace DULUTH MINNESOTA
(City, town, or county) (State or foreign country)

10. Usual occupation CONSTRUCTION WORKER

11. Industry or business.....

12. Name UNKNOWN 9

13. Birthplace O.K.
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN 9

15. Birthplace O.K.
(City, town, or county) (State or foreign country)

16. (a) Informant MISS BUREK

(b) Address 2331 MULLANPHY

17. (a) BURIAL (b) Date thereof 11-4-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director: Gullen Kelly

(b) Address 4386 Lindbergh

19. (a) NOV 4 1947 (Date received from Registrar)

J. Prosser (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15th
year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from 10 am
....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Duration

Immediate cause of death.....

Due to AORTIC STENOSIS

Due to W.M.A. IN

Other conditions.....
(Include pregnancy within 3 months of death) 92

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of 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?..... 3
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature Patrick B. Taylor, Dep Cor
1300 Clark (Dr. or other) Date signed 11-4-47

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

MOTHER FATHER

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.....

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, fact should be so stated above.