

#66194

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

FILED JUN 21 1948

Registration District No. 1818

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

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

State File No. 21294

215348

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starklof  
 (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)

3. (a) PRINT FULL NAME THOMAS BURT O'LEARY

3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. 491-12-7229

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased: JAN 10 1880  
 (Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 24  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: DONNETERRE MO.  
 (City, town, or county) (State or foreign country)

10. Usual occupation nil

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

12. Name JEREMIAH O'LEARY13. Birthplace IRELAND  
(City, town, or county) (State or foreign country)14. Maiden name MARGARET ELIZABETH CLAYBORN15. Birthplace VA  
(City, town, or county) (State or foreign country)16. (a) Informant MAY O'LEARY(b) Address 6149 CRESCENT17. (a) BURIAL (b) Date thereof JUN 12 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation DONNETERRE MO(d) Signature of funeral director Cullen - Kello(b) Address 4384 Lindell19. (a) JUN 11 1948 (b) J. Budeck  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 000  
 (c) City or town 6149 CRESCENT St. Louis 17  
 (If outside city or town limits, write "RURAL") 9  
 (d) Street No. 6149 CRESCENT 0  
Memorial (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10th  
 year 1948 hour 2 minute 10 P M.

21. I hereby certify that I attended the deceased from 5/11/48  
 \_\_\_\_\_, 19\_\_\_\_, to June 10th 1948

that I last saw him im alive on June 10th 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis  
lung, spleen, kidney, epididymis

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

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

Other conditions: \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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 1517 Lafayette Jr 6/10/48 M.D.

Address \_\_\_\_\_ Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

**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 James A. Lammert

Licensed Embalmer No. 4142

P. O. Address St. Louis

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
5348  
Registrar's No. \_\_\_\_\_

Registration District No. 316

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(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)

3. (a) PRINT FULL NAME Thomas B O'Leary

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 10 (Month) (Day) (Year)

8. AGE: 68 Years Months Days If less than one day hr. min.

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

10. Usual occupation Nil

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredeek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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

Other conditions (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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

JUN 24 1948

S-21201

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