

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3501

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3469</u>		Registrar's No. <u>641</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Perry</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Pinckneyville</u>		d. STREET ADDRESS (If rural, give location) <u>0</u> <u>3</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Francis</u>			b. (Middle) <u>Edgar</u>		c. (Last) <u>O'Neil</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>11</u> (Year) <u>1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>July 10, 1885</u>		9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 MIN. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Michael O'Neil</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Ann Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Dora Ann O'Neil</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William O'Neil, Granite City, Ill.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Unknown</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) state the underlying cause last. <u>Radical mastoid was done under general anesthesia left the patient in good condition. When removed from cut to bed patient died and expired within a few minutes. Autopsy was done and no anatomical cause.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Mastoiditis</u>						INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <u>1-11-1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Chronic Mastoiditis</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Richmond Heights St. Louis</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Richmond Heights St. Louis Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-12-48</u> to <u>1-11-49</u> , 19____, that I last saw the deceased alive on <u>1-11-49</u> , 19____, and that death occurred at <u>10:10 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Walter M. D. O.</u>				23b. ADDRESS <u>4500 Olive St. St. Louis 8 Mo.</u>		23c. DATE SIGNED <u>1-11-1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>1-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pinckneyville, Ill.</u>		24d. LOCATION (City, town, or county) (State) <u>Pinckneyville, Ill.</u>			
DATE REC'D BY LOCAL REG. <u>1-12-49</u>		REGISTRAR'S SIGNATURE <u>Theresa Cunningham</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe - St. Louis, Mo.</u>			

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

6
8
3

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, ~~on~~ by _____

Student Embalmer No. _____

working under my personal supervision.

Signed Guy W Wilkinson

Signed _____
Student Embalmer

Licensed Embalmer No. 3575

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.