

FILED MAR 27 1950

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 7752

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>328</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>7 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Route #5 Wash. Twp.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>0110 Twp.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) <u>Katherine</u>		c. (Last) <u>O'Connor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 17 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Sept. 8, 1878</u>		9. AGE (In years last birthday) (If under 1 year: Months) (If under 24 hrs.: Days) (Hours) (Min.) <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse &amp; Anesthetist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Madison, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John O'Connor</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Kenney</u>		14. NAME OF HUSBAND OR WIFE <u>Single</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Anna M. O'Connor Route # 5</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>Uremia</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Nephritis</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arterio sclerotic Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3/9/50</u> <u>3/6/50.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) <u>BURIAL</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>590X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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>3/9</u> <u>1950</u> to <u>3/17</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3/17</u> , 19 <u>50</u> , and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank J. Nandegan MD</u>				23b. ADDRESS <u>St. Joseph Mo 620 North St.</u>		23c. DATE SIGNED <u>3/17/50.</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/20/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 24, 1950</u>		REGISTRAR'S SIGNATURE <u>E. G. Jenkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman W. Sederfaden</u>		ADDRESS <u>1802 Union St.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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**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 \_\_\_\_\_

\_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_  
Student Embalmer

Signed Robert H. Gaph

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.