

FILED MAY 19 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18882**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3069** Registrar's No. **1207**

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ill. b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) Richmond Heights | | c. CITY (If outside corporate limits, write RURAL and give township) Evanston | |
| c. LENGTH OF STAY (In this place) 5-months | | d. STREET ADDRESS (If rural, give location) 309 Kedzie Ave. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital | | | |

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|---|-------------------------------|---|--|--|--|
| 3. NAME OF DECEASED (Type or Print) Marie O'Loughlin | | | 4. DATE OF DEATH (Month) (Day) (Year) May 9 1950 | | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M. | 8. DATE OF BIRTH July 3, 1916 | | 9. AGE (In years last birthday) 33 If UNDER 1 YEAR: Months 10 Days 6 If UNDER 4 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME John J. Griffin | | 13b. MOTHER'S MAIDEN NAME Mary Harkin | | 14. NAME OF HUSBAND OR WIFE Mr. Frank O'Laughlin | |
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|---|--|--|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. John J. Griffin, 7337 Pershing Ave. | |
|---|--|--|--|---|--|

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|--|--|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkins Disease | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 201X | |

| | | | | | |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 201X | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 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 **6/11, 1931**, to **5/9, 1950**, that I last saw the deceased alive on **5/9, 1950**, and that death occurred at **38 P. m.**, from the causes and on the date stated above.

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|---|--|----------------------------|--|--|--|
| 23a. SIGNATURE G. O. Brown M.D. | | (Degree or title) U | | 23b. ADDRESS 1325 S. Grand Blvd. | |
| | | | | 23c. DATE SIGNED 5/10/50 | |

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|--|--|----------------------------------|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE May 12, 1950 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | |
| | | | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |

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|--|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. 5-11-50 | | REGISTRAR'S SIGNATURE Herbert R. Poulke | | FUNERAL DIRECTOR'S SIGNATURE Arthur J. Ronnelly | |
| | | | | ADDRESS 3840 Lindell Blvd. | |

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

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.

Student
Student Embalmer

Signed..... *W H Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.