

FILED OCT 21 1950

STANDARD CERTIFICATE OF DEATH

State File No. 35196

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 8694

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		7. TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) 5079 Queens Ave.	

3. NAME OF DECEASED (Type or Print) Sister Mary Louis O'Neil			4. DATE OF DEATH (Month) (Day) (Year) Oct. 14 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH June 15 1890		9. AGE (In years last birthday) 60
			IF UNDER 1 YEAR	IF UNDER 6 HRS.	IF UNDER 15 MIN.
			3	29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) St. Joseph Nun		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chicago Ill.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Patrick O'Neil		13b. MOTHER'S MAIDEN NAME Catherine Leahy	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Peritonitis		DUE TO (c) Hypertensive Cerebrovascular Disease	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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? 1998	

22. I hereby certify that I attended the deceased from Oct 1, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE Desal A Munsch		(Degree or title)		23b. ADDRESS 33 N. Meramec	
23c. DATE SIGNED 10/14/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/16/50	
24c. NAME OF CEMETERY OR CREMATORY Nazareth Cemetery		24d. LOCATION (City, town, or county) Lemay Mo.		(State)	

DATE RECEIVED BY LOCAL REG. OCT 15 1950		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir. 2849th Euclid	
				ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.
Signed *Robert L. Brinkman*
Licensed Embalmer No. *3553*

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.