

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22456

State File No.

FILED JUN 27 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5012**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. Madison	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) Collinsville, Illinois. 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS 301 North Esplanade Street 8	
3. NAME OF DECEASED a. (First) LESLIE		c. (Last) O'FARRELL	
b. (Middle) L.		4. DATE OF DEATH (Month) (Day) (Year) 6 1 52	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Aug. 2 1900
9. AGE (In years) 51		IF UNDER 1 YEAR Months Days	IF OVER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general laboring	
11. BIRTHPLACE (State or foreign country) Collinsville, Illinois.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Patrick O'Farrel		13b. MOTHER'S MAIDEN NAME Alice DeLaney	
14. NAME OF HUSBAND OR WIFE *****		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, state year or dates of service) no	
16. SOCIAL SECURITY NO. 361-09-9138		17. INFORMANT'S SIGNATURE OR NAME Theresa Ann DeLaney 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) FAR ADVANCED PULMONARY TUBERCULOSIS PRECEDENT CAUSES Morbidity 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.	
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X	
22. I hereby certify that I attended the deceased from 5/31 , 1952 , to 6/1 , 1952 , that I last saw the deceased alive on 6/1 , 1952 , and that death occurred at 2:35 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE F.R. Braden (Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 6/1/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-2-52	24c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	24d. LOCATION (City, town, or county) (State) Collinsville, Ill. (Madison Co.)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. Charles Smith MA		25. FUNERAL DIRECTOR'S SIGNATURE Vincent New Jr. ADDRESS Collinsville, Ill	
DATE JUN 2 1952			

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

Franz Prokoff

Licensed Embalmer No. *4356*

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.