

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40571

FILED DEC 2 1952

State File No. 10177  
Registrar's No. 10177

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOHNS HOSPITAL		d. STREET ADDRESS (If rural, give location) 17 3830 SHENANDOAH AVE	

3. NAME OF DECEASED (Type or Print) a. (First) PATRICK b. (Middle) J c. (Last) O'LEARY			4. DATE OF DEATH (Month) (Day) (Year) NOV 2 1952			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 15 1889	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 7 Days 1	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER		10b. KIND OF BUSINESS OR INDUSTRY UNITED ENG - CO		11. BIRTHPLACE (State or foreign country) COUNTY CORK IRELAND		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME MARTIN O'LEARY	13b. MOTHER'S MAIDEN NAME ELIZABETH O'CONNOR	14. NAME OF HUSBAND OR WIFE WIDOWED O'Leary
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR I	16. SOCIAL SECURITY NO. 492-03-9446	17. INFORMANT'S SIGNATURE OR NAME Winifred O'Leary
		ADDRESS 3830 Shenandoah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Congestive Heart Failure		3 days
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
II. OTHER SIGNIFICANT CONDITIONS		DUE TO (b) Atrophy, Liver		6 wks
		DUE TO (c) Biliary Cirrhosis		8 wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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? 5810

22. I hereby certify that I attended the deceased from Oct 15, 1952 to Nov 1, 1952, that I last saw the deceased alive on Nov 1, 1952, and that death occurred at 10:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.	23b. ADDRESS 4957 Maryland	23c. DATE SIGNED 11/13/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 5-1952	24c. NAME OF CEMETERY OR CREMATORY CANNARY CEMETERY
		24d. LOCATION (City, town, or county) (State) ST LOUIS MO

DATE REC'D BY LOCAL REG. NOV 5 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D. W.M.	25. FUNERAL DIRECTOR'S SIGNATURE Robert L. H. Co.	ADDRESS 1905 S. Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10  
11-4-57

**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 Ben E Hoffman

Licensed Embalmer No. 4366

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.