

FILED MAY 18 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH1003 State File No. 19745  
318 REGISTRAR'S No. 4553

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		REGISTRAR'S No. 4553	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital 2819				e. STREET ADDRESS (If rural, give location) 8225 Vulcan			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) Patrick		c. (Last) O'Malley		4. DATE OF DEATH (Month) (Day) (Year) April 25, 1953	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Nov. 9, 1896	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John J. O'Malley		13b. MOTHER'S MAIDEN NAME Catherine Cavanaugh		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna Reis, 20 So. Newstead Ave.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pseudo-Tracheal anesthesia</i> ANTECEDENT CAUSES <i>Carotid artery sclerosis; during Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>exploratory laparotomy at City Hospital on April 25, 1953 at about 12:30 am</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <i>no accident</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>Accident</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Roof</i>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>St. Louis Mo</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Apr 25 53 12:30</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR  583X			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Patrick E. Taylor, M.D.</i>				23b. ADDRESS <i>1300 Clark</i>		23c. DATE SIGNED <i>5.4.53</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>5-5-53</i>		24c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Jefferson Barracks, Mo.</i>	
DATE REC'D BY LOCAL REG. <i>MAY 4 1953</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Albert H. Hoppe, 4700 Washington Blvd.</i>			

(Licensed Embalmer's Statement on Reverse Side)

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

Confession of the deceased

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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..

Student.....  
Signature of Student Embalmer

Signed.....  
*Lawrence E. Meyer*  
No Embalmer

Licensed Embalmer No.....  
P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.