

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **28578**
Registrar's No. **1860**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 590		Registrar's No. 1860	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE California b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) Rural Wellston		c. LENGTH OF STAY (in this place) 20 yrs. 4 mos.		c. CITY (If outside corporate limits, write RURAL and give township) Los Angeles		d. STREET ADDRESS (If rural, give location) 7301 St. Charles Rock Road	
3. NAME OF DECEASED (Type or Print) a. (First) Stephen b. (Middle) Murphy c. (Last) O'Callaghan				4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1955			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH Oct. 22, 1877	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months 9		IF UNDER 24 HRS. Days _____ Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) Streator, Illinois	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY RELIGION		12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Jeremiah O'Callaghan	
13b. MOTHER'S MAIDEN NAME Ellen Murphy		14. NAME OF HUSBAND OR WIFE NONE		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 Records of St. Vincent's Hospital					
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, aethenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric Thrombosis ANTECEDENT CAUSES DUE TO (b) Gangrene of Bowel DUE TO (c) (Arteriosclerotic Heart Disease) II. OTHER SIGNIFICANT CONDITIONS - (Generalized Arteriosclerosis) Schizophrenic Reaction, Chronic (Undifferentiated Type)				INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Years " "	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 450 5702				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 1-1-1948 , to 8-9- , 19 55 that I last saw the deceased alive on 8-9- , 19 55 , and that death occurred at 3:58P.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. Donnelly M.D.				23b. ADDRESS 7301 St. Charles Rock Rd.		23c. DATE SIGNED 8/9/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 11, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. 8/10/55		REGISTRAR'S SIGNATURE Herbert B. Donnelly		25. FUNERAL DIRECTOR'S SIGNATURE J. Donnelly		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 me

working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [Signature]

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.