

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 19 1957

State File No. **42418**
Registrar's No. **10767**

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| 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. COUNTY _____ | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) 3-wks. | 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 (If not in hospital or institution, give street address or location) 23 St. John's Hospital | | | e. STREET ADDRESS (If rural, give location) 2197 3730 Lindell Blvd. | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth | | b. (Middle) P. | c. (Last) O'Connell | | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1957 |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | 8. DATE OF BIRTH Nov. 27, 1887 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months 11 Days 13 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steno. Mercantile Trust Co. | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME Jeremiah O'Connell | | 13b. MOTHER'S MAIDEN NAME Mary De Lacy | | 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) no | | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Marie O'Connell, 3730 Lindell Blvd. | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malnutrition & anemia DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 334x | | | | INTERVAL BETWEEN ONSET AND DEATH _____ |
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 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) (Minute) _____ | |
| 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 Oct. 27, 1957 , to Nov. 10, 1957 , that I last saw the deceased alive on Nov. 10, 1957 , and that death occurred at 9:20 a.m. , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) Arthur J. Donnelly M.D. | | | 23b. ADDRESS 634 N. Grand St. | | 23c. DATE SIGNED 11-11-57 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Nov. 1957 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri | | |
| DATE REC'D BY LOCAL REG. NOV 12 57 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arthur J. Donnelly, 386 Lindell Blvd. | | |

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

Please call Arthur J. Donnelly Unit. When it is signed, Je. 1-1000

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 *Wm. S. Dagen*

Licensed Embalmer No. *4699*

P. O. Address *3840 Lincoln*

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.