

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027722

STATE FILE NUMBER

FILED JUL 28 1958 Registration District No. 317 Primary Registration District No. 546 541 Registrar's No. 1914

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>OVERLAND CLAYTON</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>OVERLAND 4000</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST Louis Co. Hosp</b> Length of stay in lb <b>2 wks.</b>		d. STREET ADDRESS (If outside, give location) <b>3640 BROWN</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>O'Connor</b> Last <b>O'Connor</b>			4. DATE OF DEATH Month <b>7</b> Day <b>19</b> Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Service</b>	9. AGE (In years last birthday) <b>56</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. <b>0</b>
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>MICHAEL O'CONNOR</b>		13b. MOTHER'S MAIDEN NAME <b>ELLEN GALLAGHER</b>	
14. NAME OF HUSBAND OR WIFE <b>HAZEL COBB O'CONNOR</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>494-01-0864</b>		17. INFORMANT Address <b>HAZEL O'CONNOR 3640 BROWN</b>	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction due to Coronary arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7/6/58</b> <b>7/19/58</b>
DUE TO (b) <b>4201</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Empyema of Gallbladder</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>7:25</b> Month, Day, Year <b>7-19-58</b> a.m. <b>A</b> p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>7-6-1958</b> to <b>7-19-1958</b> and last saw <sup>her</sup> him alive on <b>7-19-1958</b> Death occurred at <b>7:25 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Angelo A. Speno MD</b>		22b. ADDRESS <b>601 S. Brentwood Blvd, Clayton</b>	
22c. DATE SIGNED <b>7/20/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>7-21-1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>ORTMANN F. HANE 9222 LACKLAND</b>		25. DATE RECD. BY LOCAL REG. <b>7-20-58</b>	
26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

connected by affidavit 4/5/58 det

All diseases in Part I must be causally related.

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 *Al C. Optman* .....

Licensed Embalmer No. *3478* .....

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.