

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS FEB 23 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 153760-008690** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</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>3004 S. COMPTON</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3004 S. COMPTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>J.</b> Last <b>O'CONNOR</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1960</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>3-11-1879</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED STEAMFITTER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>TIMOTHY O'CONNOR</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE <b>CLARA 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. _____		17. INFORMANT Address <b>ELNORA HAXCH 3004 S. COMPTON</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>arterio-sclerotic <sup>hypertensive</sup> cardiac vascular disease over 10 years</b>		DUE TO (c) <b>443x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year									
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>29 April 1955</b> to <b>8 Feb. 1960</b> and last saw him alive on <b>7 Feb. 1960</b> Death occurred at <b>9:56 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Robert S. Nye, M.D.</b>				22b. ADDRESS <b>320 Arsenal St., St. Louis Mo.</b>				22c. DATE SIGNED <b>9 Feb. 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>FEB 11, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S.S. PETER &amp; PAUL CEM.</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS</b>		STATE <b>Mo</b>		
24. FUNERAL DIRECTOR <b>Thomas Katis 296 Grannis</b>			25. DATE RECD. BY LOCAL REG. <b>FEB 10 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*2.02*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Eleanor Shorin

Licensed Embalmer No. 3403

P. O. Address 2906 Gra

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.

OK 1-1-57