

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
 FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE

**FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE**

RECORDED VS JAN 13 1961

30-046634

INDEXED

Registration District No. 162 Primary Registration District No. 162 Registrar's No. 5394 140 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RURAL-MERAMEC</u>		Length of stay in 1b <u>6 mos 28 days</u>		c. CITY OR TOWN <u>WEBSTER GROVES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) <u>St. Joseph's Hosp Infirmary</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>431 TUXEDO</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>J</u> Last <u>O'DAY</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>27</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED IRON WORKER (SCULLIN STREET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>PATRICK O'DAY</u>			13b. MOTHER'S MAIDEN NAME <u>BRIDGET DOOLAGHTY</u>		14. NAME OF HUSBAND OR WIFE <u>ANN HEGARTY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes U.W.I.</u>		16. SOCIAL SECURITY NO. <u>192-09-3119-A</u>		17. INFORMANT <u>PRO. LUCH - St. Joseph's Hosp Infirmary</u>		Address <u>EUREKA</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>		
IMMEDIATE CAUSE (a) <u>CARDIAC DeCOMpensation</u>								
DUE TO (b) <u>Arteriosclerotic hypertension</u>								
DUE TO (c) <u>Cardiovascular disease.</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>old Cardiovascular accident.</u>						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 <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> / <u> </u> / <u> </u>						
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 <u>7:00 AM</u> <u>May 1960</u> to <u>12/27/60</u> and last saw him alive on <u>12/22/60</u> . Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Patrick C. Hogan MD</u>			22b. ADDRESS <u>2623 Telegraph Rd Lemay</u>			22c. DATE SIGNED <u>12/27/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Mo</u>		23e. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>		
24. FUNERAL DIRECTOR <u>Walter J. Donnelly</u>			ADDRESS <u>3840 Lindell Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>12-29-60</u>		26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>	

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

JAN 13 1961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3844

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.