

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

32472

Do not use this space.

1. PLACE OF DEATH OCT 14 1937

(a) County St. Louis, Mo. Registration District No. 791  
(b) Township St. Louis, Mo. Primary Registration District No. 1003  
(c) City St. Louis, Mo. (d) Street No. De Paul Hospital Registered No. 8526  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dennis P.O'Brien.  
(a) Residence, No. 5862 Lotus Ave. St. 6  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single.  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 22, 1863.  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 6 17  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Title Examiner  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

13. NAME John J.O'Brien.  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Connecticut.

15. MAIDEN NAME Mary Hickey.  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland.

17. INFORMANT Mrs. Ensor W.O'Brien.  
(ADDRESS) 5862 Lotus Ave.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Calvary DATE Sept. 11, 1937

19. FUNERAL DIRECTOR Arthur J. Donnelly Undt. Co.  
(ADDRESS) 3840 Lindell Blvd.

20. FILER SEP 10 1937 J. Brebeck  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9 1937  
22. I HEREBY CERTIFY, That I attended deceased from Sept 6 1937 to Sept 9 1937  
I last saw him alive on Sept 9 1937. Death is said to have occurred on the date stated above, at 8:25 m. P.M.  
The principal cause of death and related causes of importance were as follows:

Sept 9 Date of onset  
Epidemic encephalitis 9-6-37  
Other contributory causes of importance:  
Senility  
hypertension

Name of operation lumbar puncture Date of 9  
What test confirmed diagnosis lumbar puncture Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no Date of injury no  
Where did injury occur?  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no  
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no  
Do, specify no  
(Signed) Dr. J. Brebeck M. D.  
(Address) 5827 Delmar

Dr. Robt Bassett  
5427 Walmar

STATEMENT BY LICENSED EMBALMER

I, Stanley Marchlewski, Licensed Embalmer No. 2868

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

Stanley Marchlewski

Licensed Embalmer No. 2868

**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.)**