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.

REC'D MAR 13 1939

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

/791
1003

4880
Do not use this space.

Registered No. 1573

1. PLACE OF DEATH

(a) County
(b) Township
(c) City St. Louis
Registration District No.
Primary Registration District No.
(d) Street No. Desloge Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Mildred O'Brien

(a) Residence, No. 4035 Hartford St. St. 16
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William O'Brien

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-9-1904

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
34	6	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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

FATHER

13. NAME John Collins
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT William O'Brien
(ADDRESS) 4035 Hartford

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE Feb. 20, 1939

19. FUNERAL DIRECTOR (NAME) Wacker-Helderle
(ADDRESS) 2331 S. Broadway

20. FILED FEB 17 1939 J. D. Budeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12/1/38, 19.. to 2/16/39, 19.. I last saw h. alive on 2/16/39, 19.. Death is said to have occurred on the date stated above, at 10:30 p.m.
The principal cause of death and related causes of importance were as follows:

Peritonitis - post-operative following a perforated duodenal ulcer. — Date of onset

Other contributory causes of importance: general debility -

Name of operation - Exploratory - Date of 2/4/39
What test confirmed diagnosis? Was there an autopsy? yes.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19..
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
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Warren D. Moulton, M. D.
(Address) 607 - N Grand.

Licensed Embalmer's Statement on Reverse Side)

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, Frank J. Hyland Sr., or by .....

Registered Apprentice No. ....., working under my personal supervision.

Signed Frank J. Hyland Sr.

Licensed Embalmer No. 2645

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.