JUN 17 1939

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23243

96

Registration District No. 784 — Primary Registration District No. 200 — Registrar's No. 1080

1. PLACE OF DEATH:
(a) County: ST. LOUIS
(b) City or town: NORMANDY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: ST. LOUIS
(c) City or town: NORMANDY 1
(If outside city or town limits, write "RURAL")
(d) Street No.: 3839 WACO DRIVE
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: 165 John E. O'BRIEN
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife: ROSE E.
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: APRIL 20, 1868 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
71	1	27	____ hr. ____ min.

9. Birthplace: MISSOURI (City, town, or county) ____ (State or foreign country)
10. Usual occupation: RETIRED FIREMAN 0
11. Industry or business: 0
FATHER 12. Name: EDWARD O'BRIEN 0
13. Birthplace: MO. (City, town, or county) ____ (State or foreign country)
MOTHER 14. Maiden name: CATHERINE MAHER
15. Birthplace: MO. (City, town, or county) ____ (State or foreign country)
16. (a) Informant's own signature: MRS. R. J. LANEGRAF
(b) Address: 3839 WACO DRIVE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 6-19-39 (Month) (Day) (Year)
(c) Place: burial or cremation: CALVARY CEMETERY
18. (a) Signature of funeral director: ARTHUR J. DONNELLY
(b) Address: 3840 LINDELL BLVD.
19. (a) JUN 17 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1939 hour 12 minute 30 M.
21. I hereby certify that I attended the deceased from 5-1-38, 19__, to 6-17, 1939; that I last saw him alive on June 17, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral throm.	
Due to arterio sclerosis	
Due to age	
Other conditions (Include pregnancy within 3 months of death) 8 2 hr	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): none
(b) Date of occurrence: no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work: no (e) Means of injury: no
23. Signature: [signature] (M. D. or other)
Address: 340 Bermuda Date signed 6-17-39

(Licensed Embalmer's Statement on Reverse Side)

8-10 am

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.....

.....; Registered Apprentice No.....,

working under my personal supervision.

Signed Stanley Marchlewski

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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