

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13349

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **3551**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at
Ypsilville City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Margaret O'Brien **1105**

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorce

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 1 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 3 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Horton Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Ben. F. Scott **5**

13. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Lonergan

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louise Patterson

(b) Address Kansas City, Mo.

17. (a) Removal (b) Date thereof 4-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) Apr 19 1940
(Date received local registrar) (Specify local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis **20**
(If outside city or town limits write "RURAL")
(d) Street No. 2607a University St.
(If rural, give location)

Medical Certification
MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th
year 1940 hour 12 minute 30 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.
Immediate cause of death Ruptured Aortic Aneurysm. Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Manner of injury _____

23. Signature Albert H. Hoppe (M. D. or other) **5**

Address _____ Date signed 4.19.40

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

MOTHER FATHER

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 Albert G. Hoff

Licensed Embalmer No. 2971

P. O. Address.....

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.