

FILED MAY 9 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15583**

Registration District No. **713**

Primary Registration District No. **5942**

Registrar's No. _____

1. PLACE OF DEATH: **PULASKI**
 (a) County
 (b) City or town: **FORT LEONARD WOOD**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1 Candler's Bldg**
 (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: **LAWRENCE O'BRIEN JR**
 (b) If veteran, name war: **NO**
 (c) Social Security No: **327-09-5914**

4. Sex: **MALE** 5. Color of race: **WHITE**
 6. (a) Single, widowed, married, divorced: **WIDOWED**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **JANUARY 16 1919**
 (Month) (Day) (Year)

8. AGE: Years **22** Months **2** Days **17** If less than one day _____ hr. _____ min.

9. Birthplace: **HULL ILL.**
 (City, town, or county) (State or foreign country)

10. Usual occupation: **STEEL WORKER**

11. Industry or business: **CONSTRUCTION**

12. Name: **LAWRENCE O'BRIEN**

13. Birthplace: **UNKNOWN MISSOURI**
 (City, town, or county) (State or foreign country)

14. Maiden name: **MYRTLE ANDERSON**

15. Birthplace: **UNKNOWN MISSOURI**
 (City, town, or county) (State or foreign country)

16. (a) Informant: **LAWRENCE O'BRIEN**
 (b) Address: **Hull, Ill**

17. (a) **Removal** (b) Date thereof: **4-6-41**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Hull, Ill**

18. (a) Signature of funeral director: **Roller**
 (b) Address: **413/41**
 19. (a) **413/41** (b) **CP Dalrymple III**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: **ILLINOIS** (b) County: **PIKE**
 (c) City or town: **HULL**
 (If outside city or town limits, write "RURAL")
 (d) Street No.: **RURAL** (If rural, give location) **LEVEE TWP.**
 (e) If foreign born, how long in U. S. A.? **2** years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **APR** day **3**
 year **1941** hour **12:00** minute **10 A** 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: **Fractured skull - Haemorrhage**

Due to: **fall from building to concrete floor**

Due to: _____
 Other conditions: **file**
 (Includes pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

Duration _____
 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): **Accident**
 (b) Date of occurrence: **4/3/41**

(c) Where did injury occur: **St Leonard Wood**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
St Leonard Wood
 (Specify type of place)

While at work _____ Means of injury _____
 23. Signature: **Richard Frazer** (M. D. or other) _____
 Address: **Fort Leonard Wood, Mo** Date signed: **4/3/41**

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.....

W. E. Licklider

Licensed Embalmer No.....

1970

P. O. Address.....

St. James M

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, fact should be so stated above.