

S. No. 2  
M-542  
y. 5-17-39  
PI X32573

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 26 1943 318

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 506

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. John's Hospital  
(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.....  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000  
17

(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")  
9 17

(d) Street No. 3804 Shaw Ave.  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
0  
If yes, name country.....

3. (a) PRINT FULL NAME Mary O'Brien

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 15  
year 1943 hour 6 minute 15 P.M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John O'Brien

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Aug. 15, 1882  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1939  
..... 19..... to Jan. 15, 1943  
that I last saw her alive on Jan. 15, 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>5</u>	<u>0</u>	..... hr. .... min.

Immediate cause of death.....  
Cerebral hemorrhage

Due to.....  
arteriosclerosis

Due to.....  
age

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

10. Usual occupation at home

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

Major findings:  
Of operations.....

Of autopsy.....

11. Industry or business.....

12. Name Martin Walsh

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

14. Maiden name Don't know

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Wm. O'Brien

(b) Address 3804 Shaw Blvd.

17. (a) Burial (b) Date thereof Jan. 19/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Bl.

19. (a) JAN 18 1943 J. F. Bredbeck  
(Date and local registrar) (Registrar's signature)

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) Means of injury.....

23. Signature J. F. Bredbeck (M. D. or other) no  
Address 3115 S. Grand Date signed 1-16-43

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

MOTHER FATHER

3115  
D. Howard

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**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 *Ray E. Howard*

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

**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.**