

No. 2
9-4-41
17-3
X2962

FILED JUL 17 1943

318

Primary Registration District No. 1003

Registrar's No. 6269

1. PLACE OF DEATH:

(a) County: St. Louis, Missouri
(b) City or town: St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 yr. 6 mo. 9 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Louis
(c) City or town: Saint Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 2763 Bacon Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th.
year 1943 hour 12: minute 40 P.M.
21. I hereby certify that I attended the deceased from April 1st.
1st., 19 43 to July 9th., 19 43
that I last saw her alive on July 9th., 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal Obstruction *Twk*
Due to: Facal impaction
Due to: _____
Other conditions: Bronchopneumonia
(Include pregnancy within 3 months of death)

Duration
Twk
Underline the cause to which death should be charged statistically.

Major findings:
Of operations: _____
Of autopsy: As above - also fatty infiltration of heart

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. Bredisch (M: D. or other) MD
Address: City Infirmary Date signed 7/9/43

3. (a) PRINT FULL NAME: Kate O'Brien
3. (b) If veteran, name war: _____ 3. (c) Social Security No.: _____

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

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

7. Birth date of deceased: November 18 1861
(Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 21
82 8 21
If less than one day _____ hr. _____ min.

9. Birthplace: St. Louis
(City, town, or county) (State or foreign country) mo

10. Usual occupation: Seamstress

MOTHER FATHER
11. Industry or business:
12. Name: Daniel O'Brien
13. Birthplace: Ireland
(City, town, or county) (State or foreign country) 4
14. Maiden name: Mary Nannahan
15. Birthplace: Ireland
(City, town, or county) (State or foreign country) 4

16. (a) Informant: A. C. Krause
(b) Address: 5800 Arsenal Street

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: July 12 1943
(Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery Cullinane Bros.

18. (a) Signature of funeral director: _____
(b) Address: 1710 N. Grand Boul.

19. (a) J. F. Bredisch (Date received local registrar) (b) J. F. Bredisch (Registrar's signature)

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

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.....

Fred Frick

Licensed Embalmer No. *3186*

P. O. Address *St. Louis,*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 6269

1. PLACE OF DEATH:

(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Refractory
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 1/2 - 6 - mo 4 da
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5700 Arsenal
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

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

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or 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 _____ year _____ min.

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: 81 Years 7 Months 21 Days If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) JUL 23 1943 (b) J. F. Beleck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month July day 9 year 1943 hour _____ minute _____ 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 _____
Due to _____
Due to _____

Other conditions _____ (include 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) _____
(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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Handwritten initials

S-23330