

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36766**

ED NOV 29 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10071**

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

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:
De Paul 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)

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. 3634 Botanical Ave.
(If rural, give location)

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

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

(b) If veteran, name war..... No.

(c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years
17 1866
(Day) (Year)

7. Birth date of deceased. March 17 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 2 28 hr. min.

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

10. Usual occupation. At Home

11. Industry or business.....

MOTHER { 12. Name Thomas O'Brien

13. Birthplace. Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name. Elizabeth Newport

15. Birthplace. Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant. Michael O'Brien

(b) Address 3838 Flad Ave.

17. (a) Burial (b) Date thereof. 11-18-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Calvary Cemetery

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

(b) Address. 1710 N. Grand Blvd

19. (a) NOV 17 1943 J.F. Bradeau
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 15
year 1943 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from OCTOBER,
6th 1941, to NOV 15 1943.
that I last saw her alive on NOV 15, 1943.
and that death occurred on the date and hour stated above.

Immediate cause of death.....
CORONARY THROMBOSIS

Due to CORONARY SCLEROSIS

Due to SENILITY

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) Means of injury.....

23. Signature. James H. Cummings (M. D. or dentist)
Address. 444 N. Euclid Date signed 11/16/43

Duration

5 days

2 years

Many years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Truck*.....

Licensed Embalmer No. 3186.....

P. O. Address St. Louis, Mo......

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.