S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 23 1945

State File No. 25067

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1821

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: Robert Koch Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 694 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County — 000

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

(d) Street No. 4026 Delmar 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

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

3. (b) If veteran, name war —

3. (c) Social Security No. ne

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Peter

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

7. Birth date of deceased Aug (Month) 18 (Day) 1912 (Year)

8. AGE: Years 32 Months 9 Days 28 If less than one day hr. min.

9. Birthplace Hiram (City, town, or county) Mo O (State or foreign country)

10. Usual occupation Housewife

11. Industry or business —

FATHER
12. Name John Sheets
13. Birthplace (City, town, or county) Mo. O (State or foreign country)

MOTHER
14. Maiden name Minnie Duncan
15. Birthplace (City, town, or county) Mo O (State or foreign country)

16. (a) Informant Koch Hospital record
(b) Address Koch Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem

18. (a) Signature of funeral director Louis H Boppom
(b) Address Kirkwood Mo

19. (a) 7-19-1945 (Date received local registrar) (b) E. E. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1945 hour 8 minute 15 P M.

21. I hereby certify that I attended the deceased from 8-17- 1943, to 7-16 1945 that I last saw her alive on 7-16- 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	11 years
Due to 136	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury O

23. Signature Paul Humphy (M. D. or other)

Address Koch Mo Date signed 7-17-45

767

(Licensed Embalmer's Statement on Reverse Side)

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 Van M. Sizemore

Licensed Embalmer No. 4343

P. O. Address 2415 Zephyr Pl. Maplewood 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.