S. No. 2
M—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

FILED APR 22 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14402

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 847

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 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days)

In this community: Life

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.: 4035 N Newstead (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Grace Theresa O'Brien

3. (b) If veteran, name war: —

3. (c) Social Security No.:

4. Sex: F

5. Color or race: W

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

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

6. (c) Age of husband or wife if alive: 40 years

7. Birth date of deceased: May (Month) 29 (Day) 1905 (Year)

8. AGE: Years 40 Months 10 Days 14 If less than one day ____ hr. ____ min.

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

10. Usual occupation: House Wife

11. Industry or business: —

MOTHER FATHER

12. Name: James Hennessy

13. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)

14. Maiden name: Mary McGuire

15. Birthplace: St Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Koch Hospital Record

(b) Address: Koch, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/16/46 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary

18. (a) Signature of funeral director: Stroot-Carroll

(b) Address: 4600 Natural Bridge

19. (a) 4-16-46 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13 year 1946 hour 10 minute 20 A.M.

21. I hereby certify that I attended the deceased from 4-12-, 1946, to 4-13-, 1946 that I last saw her alive on 4-13-46, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Intestinal Tuberculosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: Tuberculosis — Lungs + intestine

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:

23. Signature: Paul Murphy (M. D. or other)

Address: Koch Mo. Date signed: 4-13-46

(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 Ben E. Hoffman

Licensed Embalmer No. 4366

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.