S. No. 2
M—8-43
. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24930

State File No. 0

FILED JUL 19 1946

Registration District No. 3 Primary Registration District No. 6076 Registrar's No. 1500

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 3932 Ridgeway
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town St. John's Station 0
(If outside city or town limits, write "RURAL")

(d) Street No. 3932 Ridgeway 0
(If rural, give location)

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

If yes, name country

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

3. (b) If veteran, name war -------

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

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

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

7. Birth date of deceased September (Month) 14, (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
68	10	--	hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Chris Walz
13. Birthplace (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Margaret Mueller
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mildred Meyer
(b) Address 3932 Ridgeway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 17-46 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [signature]
(b) Address 1225 Union Blvd

19. (a) 7-17-46 (Date received local registrar) (b) E. G. McGavran Mgr (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14th year 1946 hour 3: minute 30 P.M.

21. I hereby certify that I attended the deceased from June 15, 1946 to July 14, 1946 that I last saw her alive on July 13th, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to Carcinoma c̄

Due to Extensive Metas.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 1506 [illegible] Date signed 7-15-46

(Licensed Embalmer's Statement on Reverse Side)

JUL 19 1946

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 By W Williamson

Licensed Embalmer No. 3575

P. O. Address .....

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.

S. No. 2B
SM—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug.

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1500

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Clara 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 14 (Day) 18 (Year)

8. AGE: Years 68 Months 10 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 14
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occ.	3 hr.
Due to CA. OF COLON (ACCENDING) & MET. ZO	?
Due to LIVER G.B.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

46

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Wm Thos J Toon (M. D. or other) DO.

Address 506 Hodiamont Date signed 7-14-46

SUPPLEMENTARY

24930