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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. 28083

FILED SEP 10 1946

Registration District No. 294 Primary Registration District No. 2056 Registrar's No. 178

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 549½ W. Reed St.
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Randolph 88
(c) City or town Moberly 6
(If outside city or town limits, write "RURAL")
(d) Street No. 549½ W. Reed 3-0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME James L. O'Brian
3. (b) If veteran, name war ✓
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Martha
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 28th (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
84	11	4	hr. min.

9. Birthplace (City, town, or county) Va (State or foreign country)
10. Usual occupation ✓
11. Industry or business
FATHER
12. Name Hugh O'Brian
13. Birthplace (City, town, or county) Va (State or foreign country)
MOTHER
14. Maiden name Mary Kelly
15. Birthplace (City, town, or county) Va. (State or foreign country)
16. (a) Informant Mrs Martha O'Brian
(b) Address Moberly.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26-1946 (Month) (Day) (Year)
(c) Place: burial or cremation Moberly. Mo
18. (a) Signature of funeral director Malan and Son
(b) Address Moberly Mo
19. (a) Aug 26-46 (Date received local registrar) (b) Leah Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24th
year 1946 hour 7 minute 05 A.M.
21. I hereby certify that I attended the deceased from Aug-23- 1946, to Aug-24- 1946 that I last saw him alive on Aug-24- 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Senility and severe arteriosclerosis — Duration several months
Due to —
Due to —
Other conditions None
(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? —
While at work? (Specify type of place) (e) Means of injury — 0
23. Signature E. F. Shrader (M. D.)
Address Moberly Mo Date signed Aug 26 1946

267

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 9:46:16
Date Filed SEP 1946
SEP 7 - 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 Frank D. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
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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. Sept

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 178

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(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 years, months or days)

In this community

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 James L. O. Brian

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 20 1880
(Month) (Day) (Year)

8. AGE: Years 84 Months Days If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER

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) (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) Aug 26-46 (Date received local registrar) (b) Lisa Williams Lowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20 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.

	Duration
Immediate cause of death	
Due to	
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

23. Signature (M. D. or other)

Address Date signed

28083