

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED APR 8 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 3346

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution Desloge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-m.  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 0-2  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4501 Laclede Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Mary E. 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 M.

6. (b) Name of husband or wife Connie O'Brien 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased April 12th., 1872  
(Month) (Day) (Year)

|         |           |           |           |                      |
|---------|-----------|-----------|-----------|----------------------|
| 8. AGE: | Years     | Months    | Days      | If less than one day |
|         | <u>74</u> | <u>11</u> | <u>16</u> | hr. _____ min.       |

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Malachi W. Reid

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

14. Maiden name Laura Hanly  
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mr. Tom R. O'Brien

(b) Address 4501 Laclede Ave.

17. (a) Burial (b) Date thereof 3-31-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cathedral of the Holy Spirit

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) MAR 28 1947 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28th.,  
year 1947 hour 3 minute 30 a. M.

21. I hereby certify that I attended the deceased from March 1st., 1947 to March 28th., 1947,  
that I last saw h. or alive on March 27th., 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia due to Chronic Nephritis  
Duration 7 days  
Uncertain

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Acute Cholecystitis 1 mo.  
(include pregnancy within 3 months of death) Uncertain  
Arteriosclerotic Heart Disease  
PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Confirmed diagnosis given above.  
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 \_\_\_\_\_

23. Signature G. O. Brown (M. D. or other) M. D.  
Address 1325 S. Grand Date signed 3/28/47

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

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-15-36 1 10351

12-7-76

---

---

**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 W. H. Hammett

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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, above space should be left blank.**