No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED MAR 4 1948

Registration District No. 318 Primary Registration District No. 1003

State File No. 6834

Registrar's No. 1754

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution City Infirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-1-36 to 2-18-48 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-00

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

(d) Street No. 5800 Arsenal 9
(If rural, give location)

(e) Citizen of foreign country? 13 (Yes or No)

If yes, name country

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

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov 4th 1864 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	3	14	hr. min.

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

10. Usual occupation Housework

11. Industry or business

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

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

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos A Howard
(b) Address 1619 So Grand

19. (a) FEB 20 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18th year 1948 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1-1, 1947 to 2-18, 1948 that I last saw her alive on 2-18, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death cerebral apoplexy	10 days
Due to hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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? Means of injury

23. Signature C. P. Shorney (M.D. or other)

Address 5600 Arsenal Date signed 2-19-48

Jefferson City Printing Co.

(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.....Ernest W. Spillard.....

Licensed Embalmer No.....4080.....

P. O. Address.....

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.