

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14624

State File No. _____
Registrar's No. **3599**

FILED MAY 1 - 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis <i>2119</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4047 West Pine		d. STREET ADDRESS (If rural, give location) 19 4047 West Pine	
3. NAME OF DECEASED (Type or Print) a. (First) Lucille b. (Middle) O'Brien c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 16, 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH April 10, 1912
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR Months Days	IF UNDER 1 WEEK Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. <i>U</i>
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Joseph O'Brien		13b. MOTHER'S MAIDEN NAME Blanche Keeney	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 488-10-2311	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Blanche O'Brien, 4047 West Pine
MEDICAL CERTIFICATION			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Lobar Pneumonia DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 470X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:50 A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Patricia E. Taylor, Coroner		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 4-16-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial U	24b. DATE 4-17-52	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. APR 16 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harrigan-Sheahan, 4700 Washington	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *John S. Pennek*

Licensed Embalmer No. *41940*

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.