

FILED MAY 12 1955

STANDARD CERTIFICATE OF DEATH

State File No. 14332

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 600 Registrar's No. 957

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Koch, Mo.</u>		c. LENGTH OF STAY (In this city or township) <u>2 1/2</u> days	c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital-Koch, Mo.</u>			e. STREET ADDRESS (If rural, give location) <u>3558 Crittenden</u> <u>2169</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>		b. (Middle) <u>Pilkington</u>	c. (Last) <u>O'Brien</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widower</u>	8. DATE OF BIRTH <u>10-5-1897</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil (carpenter)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Patrick O'Brien</u>		13b. MOTHER'S MAIDEN NAME <u>Alice McGivney</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine DuBois</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Koch Hospital-Koch, Mo.</u> ADDRESS _____		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis Far Advanced</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Encephalomalacia, old</u>				INTERVAL BETWEEN ONSET AND DEATH <u>? 2 years</u> <u>?</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>coxix</u>			20. AUTOPSY? YES <input checked="" 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) _____			
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____	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 <u>Sep. 23</u> , 19 <u>54</u> , to <u>April 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>55</u> , and that death occurred at <u>3:15a</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Axel R. Brown M.D.</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>Robert Koch Hospital-Koch, Mo.</u>		23c. DATE SIGNED <u>4-25-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>4-27-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cairvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>4/26/55</u>	REGISTRAR'S SIGNATURE <u>Richard P. Donke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Connelly</u>		ADDRESS <u>3840 Indeel Blvd.</u>	

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 *[Signature]* Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *[Signature]*
Licensed Embalmer No. 469

P. O. Address 3840

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 embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.