

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038076

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10137

S. 300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

|  |                       |   |   |
|--|-----------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MO. b. COUNTY   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN St. Louis  |                       | c. CITY OR TOWN St. Louis   |   |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   |                       | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 2508 W. Dodier St.  |                       | d. STREET ADDRESS (If outside, give location)<br>2508 W. Dodier St.   |   |
| Length of stay in 1b   |                       | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>Catherine M. O'Brien   |                       |   | 4. DATE OF DEATH<br>Month Day Year<br>10 19 58  |
| 5. SEX<br>F  | 6. COLOR OR RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> & DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Oct. 26 1883  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                       | 9b. KIND OF BUSINESS OR INDUSTRY<br>Home  | 9c. BIRTHPLACE (City and state or country)<br>St. Louis Mo. 0                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 13a. FATHER'S NAME<br>Cornelius Foley  |                       | 13b. MOTHER'S MAIDEN NAME<br>Margaret Kinealy   |   |
| 14. NAME OF HUSBAND OR WIFE<br>Lawrence O'Brien  |                       | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No.   |   |
| 16. SOCIAL SECURITY NO.<br>None  |                       | 17. INFORMANT<br>Address<br>John L. O'Brien 2508 W. Dodier St   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>pulmonary edema</i>  |                       |   | INTERVAL BETWEEN ONSET AND DEATH<br>2-4 hours   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <i>congestive heart failure</i>   |                       |   | 1 1/2 days  |
| DUE TO (c) <i>acute myocardial infarction</i>  |                       |   | years   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>Malignancy of heart bone metastases</i>  |                       |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br>4211H   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.   |                       | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                       | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from <i>10/13/58</i> to <i>10/19/58</i> and last saw her alive on <i>10/18/58</i><br>Death occurred at <i>7:30 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated. |                       |   |   |
| 22a. SIGNATURE<br><i>W. Kinealy</i> (Degree or title)  |                       | 22b. ADDRESS<br><i>226 S. Maxwells</i>  |   |
| 22c. DATE SIGNED<br><i>10/21/58</i>  |                       | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |   |
| 23b. DATE<br><i>10/22/58</i>   |                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery  |   |
| 23d. LOCATION (City, town, or county) (State)<br>St. Louis MO.   |                       | 24. FUNERAL DIRECTOR<br>Robert D. Kinealy 2228 St. Louis Ave.   |   |
| 25. DATE RECD. BY LOCAL REG.<br><i>OCT 23 58</i>   |                       | 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith MO</i>   |   |

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 .....  
Signature of Student Embalmer

Signed *Harvey Kahle* .....

Licensed Embalmer No. *4596*  
P. O. Address *Alorissant*

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.