

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019492

STATE FILE NUMBER

2 5288

FILED JUN 15 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5561 Waterman
3. NAME OF DECEASED (Type or print) First Middle Last PAUL MUNGER O'BRYAN			4. DATE OF DEATH Month Day Year MAY 28, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Passer		10b. KIND OF BUSINESS OR INDUSTRY St. Louis State Hospital	11. BIRTHPLACE (City and state or country) Munger, Mo.
13a. FATHER'S NAME Alexander O'Bryan		13b. MOTHER'S MAIDEN NAME Minnie Munger	14. NAME OF HUSBAND OR WIFE Unavailable
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-05-0812	17. INFORMANT Address Mrs. Fred Steidel, 4950 Kerth Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			150X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. 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 5/19/59 to 5/28/59 and last saw her/him alive on 5/28/59 Death occurred at 7 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Samuel R. Joseph M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 5/28/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-30-59	23c. NAME OF CEMETERY OR CREMATORY St. Francois Memorial Cemetery	23d. LOCATION (City, town, or county) (State) St. Francois Co., Mo.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. JUN 2 '59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

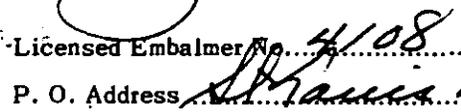
All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 4108
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.