

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023246

STATE FILE NUMBER
Registration No. 8 5470

FILED JUN 18 1959

Registration District No.

Primary Registration District No.

300
-57

92
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in lb.	d. STREET ADDRESS (If outside, give location) 4167 Castleman Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last William L. O'Brien			4. DATE OF DEATH Month Day Year June 7, 1959		
---	--	--	--	--	--

5. SEX M. d	6. COLOR OR RACE W. o	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1892	9. AGE (in years last birthday) 67	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) Electric Engr.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Litchfield, Ill. d	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	--	--------------------------------------

13a. FATHER'S NAME Thomas P. O'Brien	13b. MOTHER'S MAIDEN NAME Nellie Eagar	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World War # I	16. SOCIAL SECURITY NO.	17. INFORMANT Miss Eleanor O'Brien, 4167 Castleman Ave.	Address
---	-------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis and Hypertension		Several yrs.
	DUE TO (c) 444x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Paralytic ileus following Cholecystectomy.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1/2
---	--	---

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 Death occurred at 5/29/59 3:00 pm. to 6/7/59 and last saw him alive on 6/7/59 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert H. Cosson, M.D.	(Degree or title)	22b. ADDRESS 4401 Hampton Ave.	22c. DATE SIGNED 6/8/59
--	-------------------	-----------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 10, 1959	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City, town, or county) Litchfield, Ill. (State)
---	----------------------------	---	---

24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. JUN 8 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D. MGB
--	-------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

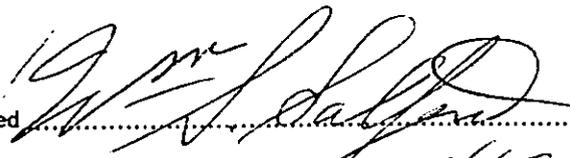
1968 AUG 8

130 to 15 pm

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. 4199

P. O. Address 3840 Linnell

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.