

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030675

FILED VS SEP 4 1959

2 7894

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		c. CITY OR TOWN <i>ST. LOUIS</i>					
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3525 MORGANFORD</i>		d. STREET ADDRESS (If outside, give location) <i>3525 MORGANFORD</i>					
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>J.</i> Last <i>O'BRIEN</i>			4. DATE OF DEATH Month <i>AUG.</i> Day <i>23</i> Year <i>1959</i>				
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>APR. 19, 1896</i>	9. AGE (last birthday) <i>63</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED MACHINIST</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A.B. CHANCE CO</i>		11. BIRTHPLACE (City and state or country) <i>ILLINOIS</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>CHARLIE O'BRIEN</i>		13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		14. NAME OF HUSBAND OR WIFE <i>-</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES W.W.I.</i>		16. SOCIAL SECURITY NO. <i>492-10-0389</i>		17. INFORMANT <i>MICHAEL O'BRIEN</i> Address <i>3525 MORGANFORD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerotic Heart Disease</i> DUE TO (b) <i>Arterio sclerosis</i> DUE TO (c) <i>420.0</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 _____ to _____ and last saw her/him alive on _____. Death occurred at <i>640 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>James S. Zuercher Deputy Coroner</i>			22b. ADDRESS <i>1300 Clark</i>			22c. DATE SIGNED <i>8/25/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>AUG. 26 1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GALVARY CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>	
24. FUNERAL DIRECTOR <i>Thomas Kutes 2906 Travis</i>			25. DATE RECD. BY LOCAL REG. <i>AUG 24 '59</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleanora Prosser

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.