

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 3456

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 <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		Length of stay in 1b <u>12 Yrs.</u>		c. CITY OR TOWN <u>Webster Groves</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>433 Cannonbury Dr.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>433 Cannonbury Dr.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LIONEL</u> Middle <u>CHARLES</u> Last <u>O'BRIEN</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-1909</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Denistry</u>		11. BIRTHPLACE (City and state or country) <u>Sappington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Leo O'Brien</u>			13b. MOTHER'S MAIDEN NAME <u>Pauline Finck</u>		14. NAME OF HUSBAND OR WIFE <u>Phoebe O'Brien</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War 2</u>		16. SOCIAL SECURITY NO. <u>492-44-0819</u>		17. INFORMANT Address <u>Phoebe O'Brien 433 Cannonbury Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis (Bacterial)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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 type="checkbox"/> NO <input checked="" 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 <u>Dec 1 1959</u> to <u>Dec. 24 1959</u> and last saw <u>him</u> alive on <u>Dec 24 1959</u> Death occurred at <u>5 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert M. Tichauer M.D.</u>			22b. ADDRESS <u>P.O. Box 6 Sappington 23 Mo</u>			22c. DATE SIGNED <u>12/24/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE <u>Dec. 28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Mausoleum</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>12-25-59</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 Edwin A. McA

Licensed Embalmer No. 3029

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.