

FILED VS JAN 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 362** STATE FILE NUMBER

| | | | | | | | | |
|---|--|---|--|--|--|--|---|-------|
| 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 | | Length of stay in 1b 22 Years | | 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 6009 North Pointe | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6009 North Pointe | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BERNARD Middle C. Last O'BRIEN | | | | 4. DATE OF DEATH Month Jan. Day 11 Year 1960 | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 5/6/1898 | 9. AGE (last birthday) 61 | 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) Postal Supervisor | | | 10b. KIND OF BUSINESS OR INDUSTRY Post Office | | 11. BIRTHPLACE (City and state or country) Edina Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Charles O'Brien | | | 13b. MOTHER'S MAIDEN NAME Katherine Wenning | | | 14. NAME OF HUSBAND OR WIFE Evelyn O'Brien | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 493 40 5156 | | 17. INFORMANT Evelyn O'Brien 6009 North Pointe 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) <u>Bronchopneumonia</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | DUE TO (b) <u>widespread intra-abdominal metastatic carcinoma</u> <u>4 mos.</u> | |
| | | | | | | | DUE TO (c) <u>Adenocarcinoma of the Pancreas</u> <u>4 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 157+ | | | | | 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>9-9-59</u> to <u>1-11-60</u> and last saw <u>him</u> alive on <u>1-10-60</u> Death occurred at <u>4:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>Arden E. Morrison, M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>St. Louis, Missouri</u> | | | 22c. DATE SIGNED <u>11/10/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 1/13/1960 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis Mo. | | | |
| 24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. JAN 12 1960 | | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>mjs.</u> | | |

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 Wilfred J. Buckley

Licensed Embalmer No. 4557

P. O. Address St Louis

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.