MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 13 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1931

61-011338
STATE FILE NUMBER

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

DOCUMENT BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 14 hours
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: DePaul Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN: Bellefontaine Neighbors
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 9340 Bellefontaine Rd.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MATTHEW Middle B Last O'BRIEN
4. DATE OF DEATH: Month February Day 24 Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/7/1902
9. AGE (last birthday): 58 years
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): custodian
10b. KIND OF BUSINESS OR INDUSTRY: Board of Education
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Isabel O'Brien
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
17. INFORMANT: Address: Isabel O'Brien - 9340 Bellefontaine Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Laennec's cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 581.1
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 March 1958 to February 24, 1961 and last saw ~~her~~ him alive on February 23, 1961
Death occurred at 7:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John T. Lawton, M.D.
22b. ADDRESS: 634 N. Grand Blvd.
22c. DATE SIGNED: Feb 25, 1961

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: Feb. 27, 1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Missouri

24. FUNERAL DIRECTOR ADDRESS: BUCHHOLZ MORTUARY-5967 W. Florissant Ave.
25. DATE RECD. BY LOCAL REG.: FEB 27 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

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.