

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 784

Primary Registration District No. 111

State File No. _____

Registrar's No. 2008

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Kathryn O'Brien Zitek: 320

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife Charles Zitek

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 4, 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>10</u>	<u>11</u>	hr. _____ min.

9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Patrick O'Brien

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mellie Muir

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Thos. P. O'Brien

(b) Address 4438a Gibson Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 11/18/39
Month (Day) (Year)

(c) Place: burial or cremation BYRNESVILLE, MO

18. (a) Signature of funeral director W. J. Croghan

(b) Address 7146 Manchester Ave.

19. (a) NOV 17 1939
(Date received local registrar)

(b) W. R. Meyer
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4438a Gibson Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15
year 1939 hour 5.00 minute 0 M.

21. I hereby certify that I attended the deceased from 10/24, 1939, to 11/15, 1939;
that I last saw her alive on 11/14, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial pneumonia

Duration 1 week

Due to _____

Due to _____

Other conditions Major systemic disease 6 weeks
(Include pregnancy within 3 months of death)

Major findings: Cerebral

Of operations _____

Of autopsy Cerebral Sclerosis

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)

(g) Means of injury _____

Signature Robert B. ... (M.D. or other)

Address 634 No. Grand Date signed 11/18/39

SEP 24 1942

Dr. Britt
Mo. Theatre B

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 _____

M. J. Crockett, Registered Apprentice No. 193-
working under my personal supervision.

Signed *Francis A. Williamson*

Licensed Embalmer No. 3565

P. O. Address 7146 Manchester

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 this body is not embalmed, above space should be left blank.