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DM-5443
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. 2978

FILED APR 8 1947

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Enroute to City Hospital #1
(If not in hospital or institution, write street number or location)

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

In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5 North Ninth Street
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) NO
If yes, name country _____

3. (a) PRINT FULL NAME JOE O'BRIANT

3. (b) If veteran, name war nil

3. (c) Social Security No. none

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 72 years hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business _____

12. Name Z.H. O'Briant

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

14. Maiden name unknown

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

16. (a) Informant Beauty B. Kalney

(b) Address 3017 Utah Street

17. (a) burial (b) Date thereof 3-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) MAR 20 1947 (b) J. H. Bredich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th
year 1947 hour 2 minutes 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary artery disease
Intermittent Hypertension

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 12H

Of operations _____

Of autopsy _____

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) _____
Means of injury _____

23. Signature Patrus 3
(D. or other)

Address _____ Date signed 3/20/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed C. W. Cooper
Licensed Embalmer No. 3830
P. O. Address 2301 Lafayette

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, fact should be so stated above.