

S. No. 2  
I-1/47  
5-17-39

25901

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED AUG 15 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7426

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **City Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 day** (Specify whether  
In this community **60 yrs.** (Specify whether  
years, months or days)

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. **1548 N. 19th., Street**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **William J. O'Brien**

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**  
6. (b) Name of husband or wife **Nonie O'Brien** 6. (c) Age of husband or wife if alive **72** years  
7. Birth date of deceased **Feb. 5th., 1871**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>76</b>	<b>6</b>	<b>1</b>	..... hr. .... min.

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

10. Usual occupation **Retired Sheet Metal Worker**

MOTHER FATHER 11. Industry or business.....

12. Name **Dennis O'Brien**

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

14. Maiden name **Ellie Norton**

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

16. (a) Informant **Mrs. Nonie O'Brien**

(b) Address **1548 N. 19th., Street**

17. (a) **Burial** (b) Date thereof **8-8-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Alfred J. Perry**  
(b) Address **3840 Lindall Blvd.**

19. (a) **AUG 7 1947** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** 6th.,  
year **1947** hour **7:13** minute **00** a. / M.

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

Immediate cause of death.....  
**Cerebral Apoplexy**

Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy.....  
Underline the cause of 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?..... (Specify type of place)

While at work?..... Means of injury.....  
3. Signature **Alfred J. Perry**  
Address **Deputy Coroner** Date signed **8-7-47**

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 W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 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.