

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community Most of his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
(c) City or town Higbee
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Edward Hugh OBrian

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Orah Dougherty

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

7. Birth date of deceased November 17, 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>0</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Hugh OBrian

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

14. Maiden name Mary Aliby
(City, town, or county) (State or foreign country)

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

16. (a) Informant Raymond OBrian
(b) Address Fayette, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47
(Month) (Day) (Year)

(c) Place: burial or cremation Bethel Cemetery

18. (a) Signature of funeral director Ralph A. Carr
(b) Address Fayette, Missouri

19. (a) 12-27-1947 (Date received local registrar) (b) Joseph Fern Sabins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10th
year 1947 hour 9:00 minute P. M.

21. I hereby certify that I attended the deceased from Dec 10, 1947, to Dec 10, 1947; that I last saw him alive on Dec 10, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death cerebral apoplexy
Duration 10 days

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

Major findings: Of operations 83A
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? 0
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature W. Lee M.D. (M. D. or other) M.D.
Address Fayette Mo. Date signed 12-23-47

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

X37823

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed 1-7-48

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

Lloyd O. Jaspering, Registered Apprentice No. *461*
working under my personal supervision.

Signed *Gaysh A. Carr*

Licensed Embalmer No. *3340*

P. O. Address *Payette Mo.*

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.