

FILED MAY 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH18511
3937
State File No. _____
Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		REGISTRAR'S NO. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <input checked="" type="checkbox"/> Kansas b. COUNTY <input checked="" type="checkbox"/> Neosho			
b. CITY (If outside corporate limits, write RURAL and give townships) OR TOWN <input checked="" type="checkbox"/> St. Louis		c. LENGTH OF STAY (in this place) 2-WKS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <input checked="" type="checkbox"/> St. Paul		8150	
d. FULL NAME OF HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/> Firmin Desloge Hospital				d. STREET ADDRESS (If rural, give location) 8			
3. NAME OF DECEASED a. (First) (Type or Print) <input checked="" type="checkbox"/> George		b. (Middle) Ignatius		c. (Last) O'Bryan		4. DATE OF DEATH (Month) (Day) (Year) <input checked="" type="checkbox"/> May 1 1950	
5. SEX <input checked="" type="checkbox"/> Male		6. COLOR OR RACE <input checked="" type="checkbox"/> White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/> Widowed		8. DATE OF BIRTH Sept. 13, 1879	
9. AGE (In years last birthday) <input checked="" type="checkbox"/> 70		IF UNDER 1 YEAR Months 9		IF UNDER 24 HRS. Days 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/> Farmer			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <input checked="" type="checkbox"/> Kansas		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.
13a. FATHER'S NAME Henry O'Bryan			13b. MOTHER'S MAIDEN NAME Sarah Hagen		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/> Rose McGann		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sister Mary Dominic, 3407 Lafayette Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Encephalitis due to ?</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senile psychosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Parkinsonism due to infection?</u>					INTERVAL BETWEEN ONSET AND DEATH 5 wks.
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE _____ (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <u>Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>April 18</u> , 19 <u>50</u> , to <u>May 1</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>50</u> , and that death occurred at <u>12:15 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>M. L. Goehausen M.D.</u> (Degree or title)				23b. ADDRESS <u>1325 So. Grand Blvd.</u> <u>St. Louis, Mo.</u>		23c. DATE SIGNED <u>May 1, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal <input checked="" type="checkbox"/>		24b. DATE <u>May 1, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Paul, Kansas</u>	
DATE REC'D BY LOCAL REG. <u>MAY 1 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>		ADDRESS <u>3840 Lindell Blvd.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed *Thomas R. Demwick*

Licensed Embalmer No. *3793*

P. O. Address *3840 Lindell*

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.