

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10834

FILED MAR 18 1957

State File No. ....

318

1003

Registrar's No. 1795

|   |                               |   |   |   |  |  |  |
|---|-------------------------------|---|---|---|--|--|--|
| BIRTH NO. _____   |                               | REG. DIST. NO. <b>318</b>   |   | PRIMARY REG. DIST. NO. <b>1003</b>  |  | Registrar's No. <b>1795</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Mo.</b><br>b. COUNTY _____ |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>   |                               | c. LENGTH OF STAY (in this place) <b>5yr 6mo 18dys</b>  |   | c. CITY OR TOWN <b>St. Louis</b>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hospital</b>   |                               |   |   | e. STREET ADDRESS (If rural, give location) <b>2109 4010 Lexington</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Joseph</b>   |                               | b. (Middle) _____   |   | c. (Last) <b>O'Brien</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Feb. 20, 1957</b>  |  |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>  | 8. DATE OF BIRTH <b>6-19-1890</b>                       | 9. AGE (In years last birthday) <b>66</b>   | IF UNDER 1 YEAR<br>Months _____ Days _____                                 | IF UNDER 24 HRS.<br>Hours _____ Min. _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Worker</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>B+O-R-R</b>  |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>LAWRENCE Co. ILLINOIS</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME <b>Dennis O'Brien</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Susan LaGard</b>   |   | 14. NAME OF HUSBAND OR WIFE <b>Loretta Hall</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO. <b>NONE</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME <b>June H. Shank</b> ADDRESS _____  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                                  |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b><br><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>420.0</b> |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>   |  |
| 19a. DATE OF OPERATION _____  |                               | 19b. MAJOR FINDINGS OF OPERATION _____  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input 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) _____   |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____  |                               | 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 <b>Aug. 2, 1951</b> , to <b>Feb. 20, 1957</b> , that I last saw the deceased alive on <b>Feb. 20, 1957</b> , and that death occurred at <b>8:15 P.m.</b> , from the causes and on the date stated above. |                               |   |   |   |  |  |  |
| 23a. SIGNATURE <b>John Niederwimmer, M.D.</b> (Degree or title)   |                               |   |   | 23b. ADDRESS <b>5800 Arsenal, St. Louis</b>   |  | 23c. DATE SIGNED <b>2-21-57</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____   |                               | 24b. DATE <b>2/23/57</b>  | 24c. NAME OF CEMETERY OR CREMATORY <b>ST CLAIR MEM.</b> |   | 24d. LOCATION (City, town, or county) (State) <b>ST CLAIR Co. ILLINOIS</b> |  |  |
| DATE REC'D BY LOCAL REG. <b>FEB 21 '57</b>  |                               | REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Sedlach Bros</b> ADDRESS <b>E. St. Louis, Ill.</b>  |  |  |  |

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

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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.....  
Signature of Student Embalmer

*not Embalmed*  
Signed *Seidlitz Bros.*

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.