

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15106**
Registrar's No. **3435**

FILED APR 26 1957

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 38 Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 4626 Sacramento	
3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) W. c. (Last) O'Brien		4. DATE OF DEATH (Month) (Day) (Year) April 8, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 24, 1892
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Engineer	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John O'Brien	
13b. MOTHER'S MAIDEN NAME Frances Leguier		14. NAME OF HUSBAND OR WIFE Martha O'Brien	
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. 488 07 3459	
17. INFORMANT'S SIGNATURE OR NAME Martha O'Brien		ADDRESS 3721 Wright 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound of skull and brain, penetrating self-inflicted gunshot wound in Rome on April 8, 1957. While suffering a temporary mental aberration	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT OR SUICIDE (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo E976+		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Apr 8 57	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 402 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE James M. Keely		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 4-10-57		23d. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Gardens	
23e. LOCATION (City, town, or county) (State) St. Louis County		23f. DATE REC'D BY LOCAL REG. APR 10 '57	
23g. REGISTRAR'S SIGNATURE Carl Smith		23h. FUNERAL DIRECTOR'S SIGNATURE Collier Mortuary	
23i. ADDRESS 10123 St. Charles Rd		23j. ADDRESS	

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.....
Signature of Student Embalmer

Signed *Sheldon Collier*

Licensed Embalmer No. *3382*

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