

33087

THE DIVISION OF HEALTH OF MISSOURI

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED OCT 14 1957

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 226

1. PLACE OF DEATH a. COUNTY <b>Saint Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Chas.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Charles</b>		c. CITY OR TOWN <b>Saint Charles</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Chas. Nursing Home</b>		Length of stay in lb <b>3 mos</b>	
d. STREET ADDRESS <b>1525 Waverly</b>		(If outside, give location) <b>8923</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine O'Brien</b>			4. DATE OF DEATH Month Day Year <b>Sept. 19, 1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1879</b>
9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>8 17</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	11. BIRTHPLACE (City and state or country) <b>West Alton, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Louis Hunn</b>		13b. MOTHER'S MAIDEN NAME <b>Irene Kuhn</b>	14. NAME OF HUSBAND OR WIFE <b>Charles O'Brien</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 Address <b>Mrs. Elmer Schaub, West Alton, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Metastatic Adenocarcinoma</b> DUE TO (b) <b>Primary Adenocarcinoma of Breast</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b> <b>3 1/2 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>170X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>July 1955</b> to <b>Sept 19, 1957</b> and last saw her alive on <b>Sept. 19, 1957</b> Death occurred at <b>8:45 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul H. Kother MD</b>		22b. ADDRESS <b>St. Charles, Mo</b>	
22c. DATE SIGNED <b>9/25/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 23, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Francis Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Portage des Sioux, Mo.</b>	
24. FUNERAL DIRECTOR <b>R.C. Dalbey &amp; Son, St. Charles, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>SEPT. 21-57</b>	
26. REGISTRAR'S SIGNATURE <b>Marella Wilson</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Frank R. Amaleng* .....

Licensed Embalmer No. *4832* .....

P. O. Address *M. Chab* .....

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.