

FILED JAN 15 1958

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 10Primary Registration District No. 3002Registrar's No. 4

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Mexico</b> TOWN		c. CITY OR TOWN <b>Mexico</b> 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>705 W. Monroe</b>		d. STREET ADDRESS (If outside, give location) <b>705 W. Monroe</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b <b>60 yrs.</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>6.</b> Year <b>1958</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Louis</b> Last <b>OBrien</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Sept. 12, 1880</b>		9. AGE (In years of birthday) <b>77</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transfer co.</b>	
11. BIRTHPLACE (City and state or country) <b>Austin, Min.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>P.V. OBRIEN</b>		13b. MOTHER'S MAIDEN NAME <b>Mary OBrien</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs James L. OBrien Mexico, Mo.</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>?</b>		17. INFORMANT Address <b>Mrs James L. OBrien Mexico, 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>Cerebral Thrombosis - with paralysis</b> <b>Respiratory Center</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> 332x DUE TO (c) <b>Cerebral Hemorrhage with Hemiplegia -</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Paralyzed since 1954 - Mental Confusion since 1954 - Reported Asthma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1954</b> <b>11-4-54</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <input checked="" type="checkbox"/>		20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year am <input type="checkbox"/> p.m. <input type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	
20f. CITY, TOWN, OR LOCATION <input checked="" type="checkbox"/>		COUNTY STATE	
21. I attended the deceased from <b>11-4-54</b> to <b>1-6-58</b> and last saw <sup>her</sup> alive on <b>1-5-58</b> Death occurred at <b>1-6-58</b> <b>2:30 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James L. O'Brien M.D.</b> (Degree or title)		22b. ADDRESS <b>Mexico, Missouri</b>	
22c. DATE SIGNED <b>1-6-58</b>		23a. BURIAL, CREMATION, OR OTHER (Specify) <b>Burial</b>	
23b. DATE <b>Jan. 8, 58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Brendans</b>	
23d. LOCATION (City, town, or county) <b>Mexico, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Precht-Hueston</b>		ADDRESS <b>Mexico, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>1-13-58</b>		26. REGISTRAR'S SIGNATURE <b>Thomas C. Dundon</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

