

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047758

Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 2

STATE FILE NUMBER

AMENDED

FILED FEB 7 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Newton</u>		a. STATE <u>Missouri</u> b. COUNTY <u>McDONALD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STELLA</u>		Length of stay in 1b <u>2 days</u>	c. CITY OR TOWN <u>Goodman</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CARDWELL MEMORIAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Cecil</u>	Middle <u>O'Brien</u>	Last <u>O'Brien</u>	4. DATE OF DEATH	Month <u>Dec.</u>	Day <u>21</u>	Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1913</u>	9. AGE (last birthday) <u>48</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>Anderson, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Michael O'Brien</u>	13b. MOTHER'S MAIDEN NAME <u>Celia Severs</u>	14. NAME OF HUSBAND OR WIFE <u>Aileen O'Brien</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Aileen O'Brien Goodman, Mo</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
IMMEDIATE CAUSE (a)	<u>Cerebral infarction Due to thrombosis.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized atherosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from Nov 6/61 to Dec 2/61 and last saw him alive on Dec 2/61
Death occurred at 2:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. D. Fountain Do</u>	(Degree or title)	22b. ADDRESS <u>not in</u>	22c. DATE SIGNED <u>1-5-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 23, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Neos Ho Memorial Park Neos Ho, Mo.</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>Robber Funeral Home Anderson, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-6-62</u>	26. REGISTRAR'S SIGNATURE <u>Mered Moberly</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

HEWING SHOULD READ

VS FEB 7 1967

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 Robert C. Rolfe

Licensed Embalmer No. 5062

P. O. Address Andover, Ma

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.