

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22653

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis**

No. **3773 Palm St**

File No.

Registered No. **16305**

St. Ward)

2. FULL NAME

Michael J. Reilly

(a) Residence. No. **3773 Palm St** St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Alice Green Reilly

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 3 1843

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Co. Cavan Ireland

10. NAME OF FATHER

Phillip Reilly

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Alice Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT (Address)

Mrs. Cath. Campbell 3773 Palm St

15.

FILED

JUL 10 1921 Max C. Starkoff

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 9 1927

17.

I HEREBY CERTIFY, That I attended deceased from **June 1926**, to **July 9**, 1927, that I last saw him alive on **Aug 8**, 1927, and that death occurred, on the date stated above, at **1205 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute myocarditis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Walter C. Frankenthal**, M. D.
, 19 (Address) **1205 Palm St**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Calvary Ave

July 11 1927

20. UNDERTAKER

Thos J. Finnan

ADDRESS

1579 S Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

