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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

791

23325

Do not use this space.

1. PLACE OF DEATH: JUL 12 1938

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 6019

(c) City Faith Hospt. (d) Street No. 2800 No. Taylor. St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

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

FAITH HOSPITAL

2. PRINT FULL NAME Reachel M. Ornellas.

(a) Residence, No. 1865 Cass Ave. St. 26

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

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: Richard J. Ornellas.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 21 1859.

7. AGE: YEARS 78 | MONTHS 7 | DAYS 9 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.: House Wife.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Jacksonville Ill.

FATHER

13. NAME: John Joaquin.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Jacksonville Ill.

MOTHER

15. MAIDEN NAME: Unknown.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown.

17. INFORMANT (ADDRESS): Rose Schuetze. 1865 Cass Ave.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Valhalla Cemetery DATE 7/5/38 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Central Funeral Home. 1841 Cass Ave.

20. FILED JUL 5 1938 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/30/38 19

22. I HEREBY CERTIFY, That I attended deceased from 6/16 1938 to 6/30 1938

I last saw her alive on 6/30 1938. Death is said to have occurred on the date stated above, at 2:30 p m.

The principal cause of death and related causes of importance were as follows:

Fracture of 5th & 6th cervical vertebrae & terminal lobar pneumonia

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 6-9 1938

Where did injury occur? Home - St Louis Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. In home

Manner of injury Fell down stairs

Nature of injury Frac. of 5th & 6th cervical vertebrae

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) A J Signarelli M. D.

(Address) 1829 Cass

(Licensed Embalmer's Statement on Reverse Side)

6019

6019

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 .....,

Registered Apprentice No....., working under my personal supervision.

Signed Albert G. Hoppe

Licensed Embalmer No. 2971

P. O. Address.....

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 this body is not embalmed, above space should be left blank.