

FILED APR 24 1942 20
Registration District No.

Primary Registration District No. 5822

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Conception Jet Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Zellerbach Dr 70
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 52-2-26 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nodaway
(c) City or town Conception Jet
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BERNARD Ferdinand O'Reilly

3. (b) If veteran, name war No
3. (c) Social Security No. 710

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 29 1870
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days 26
If less than one day hr. _____ min. _____

9. Birthplace Brookville Pa
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Matthew O'Reilly

13. Birthplace Irish
(City, town, or county) (State or foreign country)

14. Maiden name Conchona
15. Birthplace Brookville Pa
(City, town, or county) (State or foreign country)

16. (a) Informant Hilda O'Reilly

(b) Address Conception Jet Mo

17. (a) Buried (b) Date thereof 3 28 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Conception Jet Mo

18. (a) Signature of general director W. R. Fisher

(b) Address Conception Jet Mo

19. (a) 3-27-42 (b) W. R. Fisher
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 24
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cerebral thrombosis

Due to _____

Other conditions 94a
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____
Or autopsy Cerebral thrombosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. R. Fisher (M. D. or other) _____

Address Marionville Mo Date signed 3-27-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

14
0
0

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.....

Laton Phillips

Licensed Embalmer No.....

1898

P. O. Address.....

Stantbury 2110

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, fact should be so stated above.