

FILED MAR 6 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1944 Provenchere Pl.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME Elizabeth C. Reilly

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

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife John W. Reilly
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 18, 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>10</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER, FATHER

11. Industry or business _____

12. Name Unkn. Braedstadt

13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant Archib F. Reilly
 (b) Address 1944 Provenchere Pl.

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 3-2-44
(Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter + Paul Cem.

18. (a) Signature of funeral director Will Bro. L. Hilo
 (b) Address 1929 S. Jefferson Av.

19. (a) FEB 29 1944
(Date received local registrar) (b) J. F. Brediek
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1944 Provenchere Pl.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country U

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb. day 26
 year 1944 hour 12 minute noon M.

21. I hereby certify that I attended the deceased from Sept. 15, 1944 to Feb. 26, 1944
 that I last saw her alive on Feb. 22, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to 938

Due to _____

Other conditions Chronic cholelithiasis
(Include pregnancy within 3 months of death)
non-calculous

Major findings: none

Of operations _____

Of autopsy _____

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)
 (c) Means of injury fall

23. Signature Wm. R. Nye (M. D. or other) _____
 Address 2931 S. Brown Ave. Date signed 2/28/44

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.....

W E Morris

Licensed Embalmer No. 3360

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, fact should be so stated above.