

FILED APR 15 1944

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 880

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Manchester Nurs Home
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Eliya Ann Reyes

(b) If veteran, name was _____

(c) Social Security No. None

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

Henry

6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased

Mar 27 1867

(Month) (Day) (Year)

8. AGE:

Years 77 Months 0 Days 15
If less than one day hr. _____ min. _____

9. Birthplace

Jefferson Co Mo

10. Usual occupation

Retired Housewife

11. Industry or business

MOTHER FATHER

12. Name William Gilmore

13. Birthplace Jefferson Co Mo

14. Maiden name Eliya A Bowler

15. Birthplace Unknown link 9

16. (a) Informant

Goldie Newsome

(b) Address

#15 Ann Oak Valley Park Mo

17. (a)

Burial (b) Date thereof 4-13-44

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Burns Cem

18. (a) Signature of funeral director

Louis H Bopp Inc

(b) Address

Turkwood Mo

19. (a)

APR 13 1944

(b) E. J. McHarran, M.D.

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1944 hour 4 minute 45 A M.

21. I hereby certify that I attended the deceased from Dec 1
1943, to April 11, 1944;

that I last saw her alive on April 9, 1944;

and that death occurred on the date and hour stated above.

Immediate cause of death chronic myelocytic

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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) (e) Means of injury _____

23. Signature E. J. McHarran M.D. (M. D. or other)

Address 3507 Poloma Date signed 4-11-44

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

96
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.....
Van M. Brewer

Licensed Embalmer No. 4843

P. O. Address 7415 Zephyrus Pl
Highland Park, MI

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.

PAID BY STATE