

FILED FEB 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7190

State File No. ....

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 431

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Mary's Hospital  
(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 Bridget Reagan

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William Reagan 6. (c) Age of husband or wife if alive years

7. Birth date of deceased February 18 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 11 23 hr. min.

9. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER {  
12. Name John Brodweick  
13. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Margrette Brogan  
15. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Joe W. Reagan

(b) Address Montgomery City, Mo.

17. (a) Burial (b) Date thereof 2-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montgomery City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) 4700 Washington Blvd.

19. (a) FEB 14 1945 (b) C. G. Dawson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery  
(c) City or town Montgomery City 70  
(If outside city or town limits, write "RURAL")  
(d) Street No. ....  
(If rural, give location) 1  
(e) Citizen of foreign country? 1 (Yes or No) 0  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11  
year 1945 hour 11:45 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1 1945 to Feb 11 1945  
that I last saw her alive on Feb 10 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 mo  
Due to Arterio Sclerotic Heart Disease 5 yrs

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

Major findings:  
Of operations.....  
Of autopsy..... g30

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: R. Russell (M. D. or other) 1/14/45  
Address 3720 Washington Date signed.....

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

DEC 2 1946

**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. W. Wilkinson  
Licensed Embalmer No. 3578  
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.**