

**FILED MAR 16 1945**  
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.....  
(b) City or town..... **St. Louis,**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1520 Lafayette Ave.**  
(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..... **13**  
(c) City or town..... **St. Louis,**  
(If outside city or town limits, write "RURAL")  
(d) Street No..... **1520 Lafayette Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Margaret O'Reilly**

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

4. Sex **Female** 5. Color or race **Wht.** 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 **Unknown** **About 1886**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>About 60</b>	<b>Unknown</b>		hr. min.

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

10. Usual occupation..... **Housework**

11. Industry or business.....

MOTHER FATHER { 12. Name..... **Thomas O'Reilly**

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

14. Maiden name..... **Mary Kerwin**

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

16. (a) Informant..... **Nora O'Reilly Young**

(b) Address..... **1520 Lafayette Ave.**

17. (a) **Burial** (b) Date thereof..... **3/5/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Calvary**

18. (a) Signature of funeral director..... **J. F. Brennan**

(b) Address..... **1926 Allen Ave.**

19. (a) **MAR 4 1945** (b) **J. F. Brennan**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **March** day **2**  
year **1945** hour **7** minute **30** P. M.

21. I hereby certify that I attended the deceased from **9/26/18**  
1944, to **3/3** 1945  
that I last saw her alive on **3/2** 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Metal Refrigeration 10 months**  
**Chronic Bronchitis 10 months**  
**Refrites, Chr 10 months**

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations..... **13/1**  
Of autopsy.....

Duration  
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.....

Signature..... **Albert F. Bina** (M. D. or other)  
Address..... **1541 1/2 St** Date signed **3/3/45**

**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 me

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

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen av

**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.**