

FILED AUG 20 1945
Registration District No. 196

Primary Registration District No. 3026

Registrar's No. 195

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Indep. Sant Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community 64 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 703 W. Lexington
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Miss Ann O'Reilly

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 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 September 15, 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>10</u>	<u>2</u>	<u>-</u> hr. <u>-</u> min.

9. Birthplace Essexham Canada
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Charles Patrick O'Reilly

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

14. Maiden name Katherine Hogan

15. Birthplace St. Johns New Brunswick
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Mary O'Reilly

(b) Address 703 W. Lexington St. Indep. Mo.

17. (a) Burial (b) Date thereof July 19, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills Mts., Mo.

18. (a) Signature of funeral director Atty Mitchell

(b) Address 310-11 Main St. Independence Mo.

19. (a) 7-17-1945 (b) James R. Ross
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17
year 1945 hour 3:35 a.m. minute _____ M. _____

21. I hereby certify that I attended the deceased from July 15, 1945 to July 17, 1945
that I last saw her alive on July 16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Pneumonia Duration 2 days

Due to Cardiac Hypertrophy

Due to Probable Pulmonary Neoplasm

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 Ethel Watson (M.D. or other) _____

Address 129 W. Lexington Date signed 7-17-45

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

1143

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 Henry S. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep. Mo.

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.