

FILED APR 2 1946

Registration District No. **7**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH

(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **711 Jefferson**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **life** years, months or days

3. (a) PRINT FULL NAME **DR. GEORGE THOMAS REILY**

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

4. Sex **MALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **CHRISTINE REILY** 6. (c) Age of husband or wife if alive **DK.** years
7. Birth date of deceased **Feb 24 1873**
(Month) (Day) (Year)

8. AGE: Years **73** Months **0** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **SALLAWAY CO. MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **DENTIST**

11. Industry or business _____

MOTHER FATHER { 12. Name **SAM REILY**
13. Birthplace **DK.** (City, town, or county) (State or foreign country)
14. Maiden name **DK.**
15. Birthplace **DK.** (City, town, or county) (State or foreign country)

16. (a) Informant **MRS G. T. REILY**

(b) Address **FULTON, MO**

17. (a) **BURIAL** (b) Date thereof **MAR 9, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **HILL-CREST**

18. (a) Signature of funeral director **Glen Y. Mason**

(b) Address **712 Court St. Fulton, Mo.**

19. (a) **3-9-1946** (b) **Joan Monokhoff**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CALLAWAY**
(c) City or town **Fulton**
(If outside city or town limits, write "RURAL")
(d) Street No. **711 JEFFERSON**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR.** day **8**
year **1946** hour **2** minute **20** A. M.

21. I hereby certify that I attended the deceased from **May 1945** to **Mar 5 1946**
that I last saw him alive on **Mar 5 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chro. Pulmonary Tuberculosis** Duration **10 yrs**

Due to **Tuberculosis of Knee Joint** **1 yr.**

Due to _____

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

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: **30**
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 **John Brown** (M. D. or other) **MD**

Address **Fulton, Mo** Date signed **3-10-46**

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 4-1-46

APR 11 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 Glen Y. Mauvin
Licensed Embalmer No. 3725
P. O. Address Fulton, 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.