

FILED JUL 3 1946

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution **St. Louis City Hospital**
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**
(Specify whether _____)

In this community _____
years, months or days

B

3. (a) PRINT FULL NAME **ROSE REILLY**

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

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 **February 28 1969**
(Month) (Day) (Year)

8. AGE: Years **77** Months **3** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **Robert J Reilly**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Holtschneider**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs L R. Reilly** **Sister in Law**

(b) Address **3400 Chippewa**

17. (a) **Burial** (b) Date thereof **June 28 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Petz Funeral Home**

(b) Address **3029 Lafayette Ave**

19. (a) **JUN 27 1946** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **716 Hawk St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**
year **1946** hour **1:15** minute _____ A. M.

21. I hereby certify that I attended the deceased from **June 24**
_____ 19 **46** to **June 26** 19 **46**
that I last saw h. or alive on **June 26** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Sexualized peritonitis**
Defecated small bowel "flum"
Intestinal obstruction due to post-operative adhesion
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: Of operations **Same**
Of autopsy **Same**

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 **F. Thomas** (M. D. or other) _____
Address **1515 Lafayette Avenue** Date signed **6/26/46**

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

20983

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 Ernest W. Spillars

Licensed Embalmer No. 4080

P. O. Address 3836 Baticinell

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.