

S. No. 2  
PM 9-13  
v. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28750**

**FILED AUG 30 1947**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3058** Registrar's No. **140**

**1. PLACE OF DEATH:**

(a) County St. Charles

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

(c) Name of hospital or institution: St. Joseph Hospt. A  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 hours  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Mary T. Reller

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Bernard Reller deceased 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Dec. 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>7</u>	<u>13</u>	----- hr. min.

9. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Hembrock

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Wolf

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Ed. B. Reller

(b) Address Ethlyn Mo.

17. (a) Burial (b) Date thereof 8-6-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Monroe Mo.

18. (a) Signature of funeral director E. A. Keith

(b) Address Franklin Mo.

19. (a) Aug 26 47 (b) Pamela Hamilton  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Lincoln 57

(c) City or town Ethlyn Mo. 0  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No) 1  
If yes, name country: \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug. day 3  
year 1947 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 31  
21, 1947, to Aug 3, 1947.  
that I last saw h. s. r. alive on Aug 3, 1947.  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis 10 yrs  
generalized arteriosclerosis 20 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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:

(c) 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 0

23. Signature L. B. Behan M. D. / J. J. O'Fallon, M.D. (M. D. or other) \_\_\_\_\_  
Address O'Fallon, Mo. Date signed 8/8/47

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

OCT 10 1947  
11

Date Filed AUG 29 1947

District File Number

District Health Officer No. 9,

RECEIVED

SEP 3 1953

APR 27 1952

APR 30 1952

SEP 1

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 *E. A. Keilly*

Licensed Embalmer No. *Dallon 837*

P. O. Address *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.