No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

3562

FILED JAN 10 1948

State File No.

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 64

96

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 83 days (Specify whether
In this community 70 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0 0 0
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5961 Harvey 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME REILLY, JOHN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Margaret Walsh Reilly

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April (Month) 8 (Day) 1872 (Year)

8. AGE:

Years	Months	Days	If less than one day
75	9	0	hr. min.

9. Birthplace St. Louis County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Jim Reilly
13. Birthplace (City, town, or county) New York (State or foreign country)

MOTHER
14. Maiden name Bridget Hughes
15. Birthplace (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) 1 (Day) 12 (Year) 48
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) 1-9-48 (Date received local registrar) (b) Carl C. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
year 1948 hour 1 minute 10 P. M.

21. I hereby certify that I attended the deceased from 10-17-47, 19..., to 1-8-48, 19...;
that I last saw him alive on 1-8-48, 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	14 mo. (??)
Due to 13 b	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature [illegible] (M. D. or other)
Address Robert Koch Hospital Date signed 1/9/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 W H Van Matre.

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette.

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.