

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3049 -61-039653
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3049

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryland Heights</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>Maryland Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>509 Fee Fee Rd.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>509 Fee Fee Rd.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Ida</u> Last <u>Reilley</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-74</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Bridgeton, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Carl W. Henrichs</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Siebe</u>	
14. NAME OF HUSBAND OR WIFE <u>George Reilley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>George Reilley-509 Fee Fee Rd.,</u>		Address <u>Maryland Hghts., Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 day</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20e. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20h. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21. I attended the deceased from <u>10-27-61</u> to <u>10-29-61</u> and last saw her <u>alive on 10-27-61</u> Death occurred at <u>11:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Typed or title) <u>J. B. Williams, D.O.</u>		22b. ADDRESS <u>10426 Lakeland</u>		22c. DATE SIGNED <u>10-30-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-1-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fee Fee Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Bridgeton, Mo.</u>		23e. FUNERAL DIRECTOR <u>Baumann Bros. Inc.</u>		23f. ADDRESS <u>2504 Woodson Rd.,</u>	
23g. DATE RECD. BY LOCAL REG. <u>10-30-61</u>		23h. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>		23i. ADDRESS <u>Overland, Ill.</u>	

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed David E. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.