

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

6406

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township Raw Primary Registration District No. 1002 Registered No. 565  
 City Kansas City (No. St. Josephs Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mary Ann Reilly  
 (a) Residence No. 4319 Adams St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

|   |              |   |             |  |  |
|---|--------------|---|-------------|--|--|
| <b>3. SEX</b><br><u>Female</u>  |              | <b>4. COLOR OR RACE</b><br><u>white</u> |             | <b>5. SINGLE, MARRIED, WIDOWED OR DIVORCED</b><br><u>married</u> |  |
| <b>5A. IF MARRIED, WIDOWED, OR DIVORCED</b><br>HUSBAND OF _____<br>(OR) WIFE OF <u>Joseph P. Reilly</u> |              |   |             |  |  |
| <b>6. DATE OF BIRTH (MONTH, DAY AND YEAR)</b> <u>June 15 1891</u>                                       |              |   |             |  |  |
| <b>7. AGE</b>   | <b>YEARS</b> | <b>MONTHS</b>                           | <b>DAYS</b> | <b>IF LESS than 1 day, hrs. or min.</b>                          |  |
|   | <u>37</u>    | <u>7</u>                                | <u>17</u>   |  |  |
| <b>8. OCCUPATION OF DECEASED</b>  |              |   |             |  |  |
| (a) Trade, profession, or particular kind of work <u>Housewife</u>                                      |              |   |             |  |  |
| (b) General nature of industry, business, or establishment in which employed (or employer) _____        |              |   |             |  |  |
| (c) Name of employer _____  |              |   |             |  |  |

**9. BIRTHPLACE (CITY OR TOWN)** \_\_\_\_\_  
 (STATE OR COUNTRY) Kansas

**10. NAME OF FATHER** John A. Reiter

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** \_\_\_\_\_  
 (STATE OR COUNTRY) Austria

**12. MAIDEN NAME OF MOTHER** Wlara Morgan

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** \_\_\_\_\_  
 (STATE OR COUNTRY) Kansas

**14. INFORMANT** Jack Reiter  
 (Address) 4315 Adams

**15. FILED** 24 29 M M Cray  
 \_\_\_\_\_ 19\_\_\_\_  
 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Feb. 2 1929

**17. I HEREBY CERTIFY**, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ 12 noon \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
1. Myocardial infarction  
2. Hypertension of the heart  
3. Systemic arteriosclerosis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 da.

**CONTRIBUTORY (SECONDARY)** \_\_\_\_\_  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH?** Yes DATE OF \_\_\_\_\_

**20. WAS THERE AN AUTOPSY?** \_\_\_\_\_

**WHAT TEST CONFIRMED DIAGNOSIS?** \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
7/3 . 1929 (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Shawnee **DATE OF BURIAL** 2/5 1929

**20. UNDERTAKER** H.W. Gates **ADDRESS** K.C.K.

NO. 5 1341

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399  
 Township..... Primary Registration District No. 1002  
 City W. City (No.....) St. .... Ward)

File No.....  
 Registered No. 365

**2. FULL NAME**

(a) Residence. No..... St. .... Ward.  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

*Mary Ann Reilly*

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 7/4, 1929 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2 1929

17. I HEREBY CERTIFY That I attended deceased from..... to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Pyemia & Abscesses of lungs, spleen & kidneys to*  
 (duration) ..... yrs. .... mos. .... ds.  
 CONTRIBUTORY (SECONDARY) *Osteomyelitis of Spleen*  
 (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

This was a staphylococcus infection  
There was an underlying history  
of falling, injuring back.

EA Ferguson

5-6406