

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCT 26 1937

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

35397  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 1170  
 (b) Township Jefferson Primary Registration District No. 6248-H.s. Registered No. 206-5  
 (c) City Richmond Heights (d) Street No. St. Mary's Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 1 1/2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Betty Jane O'Reilly,

(a) Residence, No. 5833 Itaska St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 10th, 1925</u>		
7. AGE YEARS <u>12</u>	MONTHS <u>5</u>	DAYS <u>8</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>student.</u>		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis, Mo.</u>		
13. NAME <u>James G. O'Reilly</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis, Mo.</u>		
15. MAIDEN NAME <u>Lillian Stone</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis, Mo.</u>		
17. INFORMANT (ADDRESS) <u>James G. O'Reilly 5833 Itaska</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Peter's Church 9-21-37</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Southern Funeral Home 6322 S. Grand Blvd.</u>		
20. FILED <u>Sept. 20, 1937. Sam B. Bassett Local Registrar.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-18, 1937

22. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1937, to Sept 18, 1937.  
 I last saw him alive on Sept 18, 1937. Death is said to have occurred on the date stated above, at 4:30 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Acute Respiratory Failure, Epidemic  
 Date of onset

Other contributory causes of importance:  
Cerebral

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chaseid Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) Ph. Campbell, M. D.  
 (Address) 3239 Franklin

78

4922 Hampton 2.4  
3239 Danville 10-12

STATEMENT BY LICENSED EMBALMER

I, Frank Ludwig, Licensed Embalmer No. 2504

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E. Frank Ludwig

No. 2504 or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

*Frank Ludwig*

Licensed Embalmer No. 2504

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.)

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

35-397  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 1170  
 (b) Township Richmond Hts. Primary Registration District No. 6248 H. Registered No. ....  
 (c) City Richmond Hts. Street No. .... (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Betty Jane O'Reilly  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 2 (Write the word)

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, .....hra. or .....min.  
12 5 8

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

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

FATHER  
 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sept 20 1937 Sam W. Beckett Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-18 1937

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19.....  
 I last saw h. .... alive on ....., 19..... Death is said to have occurred on the day stated above, at ..... m.  
 The principal cause of death, and related causes of importance were as follows:  
Encephalitis - epidemic Date of onset 9/13/37

Other contributory causes of importance: 17

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify .....  
 (Signed) P. B. Cappelmann M. D.  
 (Address) 3239 Washington

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. OCCUPATION SHOULD BE STATED EXACTLY. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.  
 CAUSE OF DEATH IN plain terms, so that it may be properly classified.

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