

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 Days**
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **John O'Rielly**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept. 28 1868**
(Month) (Day) (Year)

8. AGE: Years **72** Months **0** Days **17** If less than one day hr. _____ min. _____

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

10. Usual occupation **Boiler Maker**
11. Industry or business **Retired**

12. Name **John J. O'Reilly**
13. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Maria Higgins**
15. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Anna Burke**
(b) Address **3659 Juniata St.**

17. (a) **Burial** (b) Date thereof **10-17-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery Cullinane Bros.**

18. (a) Signature of funeral director _____
(b) Address **1710 N. Grand Blvd.**

19. (a) **OCT 16 1940** (b) **J. B. ...**
(Date received by local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **16**
(If outside city or town limits, write "RURAL")
(d) Street No. **3659 Juniata St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **15**, year **1940** hour **10:40** minute _____ A. M. P. M.
21. I hereby certify that I attended the deceased from **October 2**, 1940, to **October 15**, 1940, that I last saw him alive on **October 15**, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death **Right hemiplegia** Duration **2 weeks**
Due to **Cerebral Vascular Accident (Left)** **2 weeks**
Due to **Generalized Arteriosclerosis and Hypertension** **10 yrs. 10 yrs.**
Other conditions (Include pregnancy within 3 months of death) **None**
Major findings: Of operations _____ Of autopsy **none**
PHYSICIAN _____ Underline the cause to 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **J. C. ...** (M. D. or other) _____
Address **1515 Lafayette Avenue,** Date signed **10/15/40**

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

MOTHER FATHER

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.....

Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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