

FILED DEC 15 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Lukes Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 Weeks**
 (Specify whether
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
 (c) City or town **University City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **6369 Pershing Ave.**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **James Archer O'Reilly M.D.**
 3. (b) If veteran, name war..... 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **5th**
 year **1947** hour **12** minute **30** A.M.
21. I hereby certify that I attended the deceased from
Oct. 6 19**39**, to **Dec 5** 19**47**
 that I last saw him alive on **Dec 5** 19**47**
 and that death occurred on the date and hour stated above.

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Jane Sever O'Reilly** 6. (c) Age of husband or wife if alive **8** years
 7. Birth date of deceased **Sept. 24, 1879**
 (Month) (Day) (Year)

Immediate cause of death
Cardiac decompensation
chronic myocarditis
 Due to **Auricular fibrillation**
 Due to.....
 Other conditions (Include pregnancy within 3 months of death).....
 Major findings:
 Of operations.....
 Of autopsy.....

8. AGE: Years Months Days If less than one day
68 **2** **11** hr. min.

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

10. Usual occupation: **Medical Doctor**

11. Industry or business:.....

12. Name: **Thomas W. O'Reilly**

13. Birthplace: **Ireland**
 (City, town, or county) (State or foreign country)

14. Maiden name: **Mary Archer**

15. Birthplace: **Ireland**
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Archer O'Reilly**

(b) Address: **6322 Pershing Ave.**

17. (a) Burial (b) Date thereof **12-6-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director: **Arthur J. Donnelly**

(b) Address: **3840 Rindell Blvd**

19. (a) DEC 5 - 1947 (b) **A. Budeck**
 (Date received local registrar) (Registrar's signature)

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.....

23. Signature: **Clara Budeck** (M. D. or other)
 Address: **3720 Washington** Date signed: **12/5/47**

DEC 21 1948

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

Stanley Marshall

Licensed Embalmer No.

2868

P. O. Address

3840 Lindell

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.