

FILED JAN 13 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's

S. 300
v. 1-57

9

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in 1b		d. STREET ADDRESS 4543 Flad Ave.	
3. NAME OF DECEASED (Type or print) First MELVILLE Middle J. Last O'REILLY		4. DATE OF DEATH Dec. 24 1957		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur-Board of Education		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
13a. FATHER'S NAME James O'Reilly		13b. MOTHER'S MAIDEN NAME Elizabeth Meehan		14. NAME OF HUSBAND OR WIFE Jessie R. O'Reilly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO.		17. INFORMANT Address Jessie R. O'Reilly 4543 Flad Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETROPERITONEAL LYMPHOMA SARCOMA				INTERVAL BETWEEN ONSET AND DEATH 1 YR.	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) _____ DUE TO (c) _____				200-1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 9:15 A. on 11/1/57 to 12/27 and last saw him alive on 12/27/57 m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE M.D. O.		22b. ADDRESS 462 N. Taylor		22c. DATE SIGNED 12/27	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 27, 1957		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
				23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. DEC 26 '57		26. REGISTRAR'S SIGNATURE Carl Smith M.D. M.B.S.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 4537

P. O. Address

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.