

REC'D FEB 10 1939

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

791  
1003805  
Do not use this space.

Registered No. 805

## 1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City Saint Louis,  
(e) Length of residence in city or town where death occurred yrs. mos. da.

Registration District No. ....  
Primary Registration District No. ....

(d) Street No. Peoples Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

170 America Reeves

(a) Residence, No. 4349a West Belle Place St. 17  
(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 Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
About 70

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) Shellbyville Tennessee

FATHER 13. NAME Unavailable

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9/11/18

MOTHER 15. MAIDEN NAME 9/11/18

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9/11/18

17. INFORMANT (ADDRESS) Dovie T. Reeves 4349a West Belle Place

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter's Cemetery DATE Jan 28 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Charles J. Gates 4107 Finney Avenue

20. FILED JAN 26 1939 J. F. Brubaker Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 25th 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 1:51 a. m.

The principal cause of death and related causes of importance were as follows:

Fracture of the Left Hip/ Arterio-Sclerosis; suffered in fall to floor at her home 4349a West Belle, on January 16th, 1939, at about 4:30 P.M.

Date of onset

Other contributory causes of importance:

Name of operation..... Date of..... No  
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 Accident Date of injury 1/16/1939

Where did injury occur? St. Louis, Mo.  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

In Home

Manner of injury..... See Above

Nature of injury.....

24. Was disease of injury in any way related to occupation of deceased? No

If so, specify.....

(Signed) J. F. Brubaker M.D.

(Address) 1300 Clark Avenue

STATEMENT BY LICENSED EMBALMER

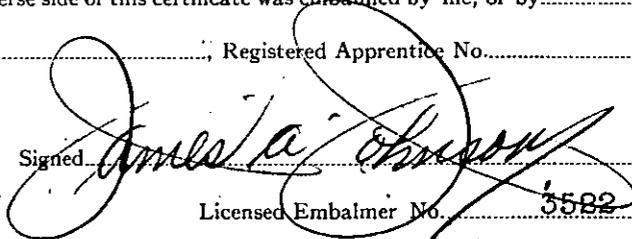
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James Arthur Johnson

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 3582

P. O. Address 4107 Finney Avenue

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, above space should be left blank.