

TEST AUG 4

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

26886  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Carondelet Primary Registration District No. 290  
 (c) City Rock (d) Street No. Rock 113 Registered No. 1311  
 (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME CLARENCE CLYDE REED  
 (a) Residence, No. 3111 Brantner 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 Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wife the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 7 1905

7. AGE YEARS 34 MONTHS 02 DAYS 20? If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman

9. Industry or business in which work was done, as saw mill, bank, etc. Insurance

10. Date deceased last worked at this occupation (month and year) Oct. 1956 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-19-1939

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1939, to July 18, 1939  
 I last saw him alive on July 18, 1939 Death is said to have occurred on the date stated above, at 5:20 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Pulmonary Tbc.  
Intestinal Tbc.

Other contributory causes of importance:  
Diabetes mellitus

Date of onset Dec., 1938  
Dec., 1938

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

FATHER  
 13. NAME Edward Walker  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisville, Ky.

MOTHER  
 15. MAIDEN NAME Elizabeth Hudson  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisville, Ky.

17. INFORMANT (ADDRESS) Decease of Malinda Turner  
3111 Brantner Place

18. BURIAL, CREMATION, OR REMOVAL PLACE Louisville Ky. DATE July 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. B. Beal & Co.  
2726 Lucas Ave.  
Rock, Mo.

20. FILED JUL 20 1939 J. R. Myers Registrar

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? X-ray; Sputum Was there an autopsy? Yes

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) Clyde R. Minter, M. D.  
 (Address) Rock, Missouri

(Licensed Embalmer's Statement on Reverse Side)

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.

**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 *Burdie Beal And*  
*A. L. Beal and C.*

Licensed Embalmer No. *2929*

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 this body is not embalmed, above space should be left blank.**