

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.

JAN 12 1940 1701

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution:
4421 S. Grand Bl.
(d) Length of stay: In hospital or institution _____
In this community _____

8. (a) PRINT FULL NAME William Reed
8. (b) If veteran, name war World
8. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gertrude Reed
6. (c) Age of husband or wife if alive D.K. years

7. Birth date of deceased Oct. 17, 1887

8. AGE: Years 52 Months 2 Days 9
If less than one day hr. _____ min. _____

9. Birthplace St. Louis Missouri

10. Usual occupation Bartender

11. Industry or business _____

MOTHER FATHER
12. Name James Reed
13. Birthplace Illinois
14. Maiden name Anna Coulson
15. Birthplace Illinois

16. (a) Informant's own signature _____
(b) Address 4421 S. Grand Bl.

17. (a) Burial (b) Date thereof Dec. 28/39
(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Weick Bros Und. Co.
(b) Address 2201 S. Grand Bl.

19. (a) DEC 27 1939 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 4421 S. Grand Bl.
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26
year 1939 hour 10 minutes 0 A.M.

21. I hereby certify that I attended the deceased from 12/23, 1939, to 12/26, 1939;
that I last saw him alive on 12/26, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cancer Lung
Cancer Larynx Primary

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____
(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 Dr. [Signature] (M. D. or other) _____
Address 3702 Grand Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

*Dr. Wallace
3702 Secorville Rd.*



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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed *Henry Stewart*.....

..... Licensed Embalmer No. 3722.....

..... P. O. Address 412 Duchouquette St......

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.