

DEPARTMENT OF COMMERCE MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF THE CENSUS  
 OCT 25 1940  
 STANDARD CERTIFICATE OF DEATH

30641

State File No. \_\_\_\_\_

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 7918

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis City Hospital #1.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 23 Days  
(Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis. 19  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3699 Olive Street.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 20,  
 year 1940 hour 3:40 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from August  
29, 1940 to September 20, 1940;  
 that I last saw him or alive on September 20, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

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? \_\_\_\_\_  
(City or town) (County) (State)

(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 W. H. J. [unclear] (M. D. or other) \_\_\_\_\_  
 Address 1515 Lafayette Ave. Date signed 9/21/40

3. (a) PRINT FULL NAME Hazel Reed

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 440-03-7861

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

6. (b) Name of husband or wife Harry Reed. 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased June 9, 1886.  
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 11 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Illinois.  
(City, town, or county) (State or foreign country)

10. Usual occupation Sewing.

11. Industry or business W.P.A.

12. Name Unknown Johnson

13. Birthplace Ohio.  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown.

15. Birthplace Ohio.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edward Huether.

(b) Address 342 No. Spring Ave.

17. (a) Cremation (b) Date thereof 9-24-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory.

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

(b) Address 3840 Lindell Blvd

19. (a) SEP 23 1940 (Date received by registrar) \_\_\_\_\_ (Registrar's Signature)

(Licensed Embalmer's Statement on Reverse Side)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....

*W. Van Matre*

Licensed Embalmer No.....

*2825*

P. O. Address.....

*4340 Lafayette*

**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.**