

1-10-39
-17-39
X21492

FEB 25 1941

Registration District No. 791

Primary Registration District No. 1003

I. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2378 So. 39th St. 3 S
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 wks 5
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Leslie D. Reid

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 16 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 9 25 hr. min.

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

10. Usual occupation Barber

11. Industry or business Own Barber Shop

12. Name: Forest L. Reid

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

14. Maiden name Annabelle Duncan

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

16. (a) Informant Sadie Jennings

(b) Address 2378 So. 39th St.

17. (a) Burial (b) Date thereof 1-14-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Montgomery City Mo.

18. (a) Signature of funeral director Marlowe Funeral Home

(b) Address Montgomery City, Mo. 64110

19. (a) JAN 15 1941 (b) J. W. Brudick
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 70
(c) City or town Montgomery City
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 11
year 1941 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from 12-25 1938 to 1-11 1941

that I last saw him alive on 1-11 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute heart failure Duration 1 wk.

Due to Chronic myo-carditis Unk.

Other conditions: Coronary heart disease
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy 123
Underline the cause to which death should be charged statistically.

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 Dr. C. B. Bess (M. D. or other) mt.
Address 3606 Graven Date signed 1-11-41

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

MOTHER FATHER

Dr. Best
3606 Records

406
406

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 Arnold W. Schene

Licensed Embalmer No. 3864

P.O. Address St. Louis, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4067
Registrar's No. 406

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(c) Name of hospital or institution: 3378 So 39 St Private Residence
not a hospital or institution
(d) Length of stay: 8 weeks
In this community 8 weeks
year, months or days

3. (a) PRINT FULL NAME Leslie D Reed
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 60 Months 9 Days 25
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 5-14-41 (b) J.F. Predeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town Montgomery City
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location) NR
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 11
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Geo. C. Bess (M. D. or other) _____
Address 3606 Prayers Date signed _____

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.....

Licensed Embalmer No.....

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, fact should be so stated above.