

S. No. 2
M-5-42
7. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8153
State File No.

FILED APR 13 1945

Registration District No. **818** Primary Registration District No. **1003** Registrar's No. **2893**

1. 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:
5228 A. Louisiana Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **17**
(d) Street No. **5228 A. Louisiana Ave.** (If rural, give location) **9 15**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Arthur J. Reed**
3. (b) If veteran, name war ********* (c) Social Security No. *********

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **29th** day **March**
year **1945** hour **6:30** minute **P.** M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lena Reed** (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **August 13 1868**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb 15**
1944 to **March 29** 19**45**
that I last saw him alive on **March 28** 19**45**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
76 **7** **16** hr. min.

Immediate cause of death **Cerebral hemorrhage (apoplexy)** Duration **7 days**
Due to.....

9. Birthplace **Illinois** (City, town, or county) (State or foreign country)
10. Usual occupation **Millman Retired**

Due to **Arteriosclerosis** **Chronic**
Other conditions.....
(Include pregnancy within 3 months of death)

11. Industry or business
12. Name **James Reed**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Anna Sanford**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Lena Reed**
(b) Address **5228 A. Louisiana Ave**

17. (a) **Burial** (b) Date thereof **March 31 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sunset Burial Park**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....

18. (a) Signature of funeral director **Frederick B. ...**
(b) Address **6409 Gravois Ave**
19. (a) **MAR 30 1945** (Date received local registrar) **J. J. Bredek** (Registrar's signature)

(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.....
Signature **J. J. Bredek** (M.D. or other) **7712 Perry Ave**
Address Date signed **3/30/45**

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.....

Harner W. Jantz

Licensed Embalmer No.

3882

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.