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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21367

FILED JUL 5 1945

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1681

1. PLACE OF DEATH:

(a) County St Louis County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bridgeton Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 8 YEARS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL")

(d) Street No. Bridgeton Mo (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HANSON Reed

3. (b) If veteran, name war No

3. (c) Social Security No. 488-18-9232

4. Sex M

5. Color or race C

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife Mable Reed

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Sept (Month) 2 (Day) 1889 (Year)

8. AGE: Years 56 Months 10 Days 26 If less than one day hr. min.

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

10. Usual occupation LABOR

11. Industry or business no

FATHER
12. Name Mac Reed
13. Birthplace Oxford (City, town, or county) Miss (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace Oxford (City, town, or county) (State or foreign country)

16. (a) Informant Mable Reed

(b) Address Bridgeton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Herman Smith

(b) Address 4247 N Lahadie Ave

19. (a) 7-2-1945 (Date received local registrar) (b) Dr. E. J. McGovern (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th year 1945 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 28th 1944 to June 28 1945; that I last saw him alive on June 27 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	1 yr
Chronic Nephritis	1 yr.
Due to	
1316	
Due to	
Other conditions Chronic Prostatitis (Include pregnancy within 3 months of death)	1 yr.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. T. Coleman M.D. (M. D. or other)

Address Pattonville Mo Date signed June 29 45

(Licensed Embalmer's Statement on Reverse Side)

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. 3522

P. O. Address 3704 Fairmount

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.