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STANDARD CERTIFICATE OF DEATH

State File No. **26059**
7018
Registrar's No. _____

FILED AUG 24 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**

(c) Name of hospital or institution: **4373 McPherson Ave. /**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether in this community _____ years, months or days)

3. (a) PRINT FULL NAME **Clarence L. Reed**

3. (b) If veteran, name war _____

3. (c) Social Security No. **493-07-3627**

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

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

7. Birth date of deceased **January 25 1909**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	36	6	14	_____ hr. _____ min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Operator**

11. Industry or business **Sterling Products Co.**

12. Name **Clarence L. Reed**

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

14. Maiden name **Rose Schmidt**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Rose Reed**

(b) Address **4373 McPherson Ave.**

17. (a) **Burial** (b) Date thereof **Aug. 11, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Wacker Helde**
(b) Address **3634 Gravois Ave.**

19. (a) **AUG 10 1945** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis** **17 / 19**
(If outside city or town limits, write "RURAL")

(d) Street No. **4373 McPherson**
(If rural, give location) **9**

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **8**
year **1945** hour **9** minute **00** P. M.

21. I hereby certify that I attended the deceased from **August 1, 1945** to **Aug. 8, 1945**
that I last saw him **alive on Aug. 8, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Indeterminate**

Due to _____

Due to **91c**

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 **M. E. Shultz** (M. D. or other) _____

Address **43604 Marshall** Date signed **8/19/45**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Robert Wheeler

Licensed Embalmer No. 2178

P. O. Address Lawrence

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7018

1. PLACE OF DEATH:

(a) County St. Louis mo
(b) City or town St. Louis mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 4373 McKruse
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

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

20. DATE OF DEATH _____ month _____ day _____ year _____ hour _____ minute _____ M.

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

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

Immediate cause of death _____

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

Due to _____
Due to _____

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

Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: _____
Of operations _____

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)

Of autopsy _____

16. (a) Informant _____ (b) Address _____

22. If death was due to external causes, fill in the following:

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

(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? _____

18. (a) Signature of funeral director _____ (b) Address _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

19. (a) AUG 27 1946 J. F. Brudeck
(Date received local registrar's certificate) (Registrar's signature)

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

26059