

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED AUG 27 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28988

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **21272**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
4590 Evans 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 3 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4590 Evans ave 119
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ALONZO Reed

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 1 1946
year 1946 hour 6:30 minute _____ M.

4. Sex male 2

5. Color or race cal

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 17th 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 1946 to _____ 1946
that I last saw him alive on 8/18/46 and that death occurred on the date and hour stated above 1946
Immediate cause of death Heart Disease 608 months
Duration _____

8. AGE: Years 75 Months 1 Days 27 If less than one day _____ hr. _____ min.

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

Due to _____

Due to _____

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

10. Usual occupation nil

11. Industry or business _____

12. Name Washington Reed

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

14. Maiden name Isabella Lackland

15. Birthplace unk Miss
(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 Isabella Richards

(b) Address 4590 Evans ave

17. (a) Burial (b) Date thereof 8-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. J. O'Connell

(b) Address 3133 Beech ave

19. (a) AUG 17 1946 (b) J. J. O'Connell
(Date received local registrar) (Registrar's signature)

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 J. J. O'Connell (M. D. or other) _____
Address 809 E. 2nd St. Date signed 8/19/46

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

217000

Handwritten notes, possibly "H.P.C. 1924"

Handwritten notes, possibly "1921"

Handwritten text, possibly "H. H. H. H."

Handwritten text, possibly "1921"

Handwritten text, possibly "1921"

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 *S. J. Watson*

Licensed Embalmer No. *2598*

P. O. Address *2769 Houston*

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.