No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 13 1947
#40783

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19271

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5467

1. PLACE OF DEATH:

(a) County: St. Louis, Missouri.

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

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: newborn (Specify whether years, months or days)

In this community:

2. USUAL RESIDENCE OF DEACEASED:

(a) State: Missouri (b) County: Out

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

(d) Street No.: 902 St. Charles (If rural, give location) Memorial 26

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

If yes, name country:

3. (a) PRINT FULL NAME: Infant ~~BABY (MALE)~~ REED

3. (b) If veteran, name war:

3. (c) Social Security No.:

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 alive: years

7. Birth date of deceased: May 26th, 1947 (Month) (Day) (Year)

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace: St. Louis City Hospital (City, town, or county) (State or foreign country)

10. Usual occupation: nil

11. Industry or business:

MOTHER FATHER

12. Name: Howard Reed

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

14. Maiden name: Virginia Hart

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

16. (a) Informant: M. Renard

(b) Address: St. Louis City Hospital.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof: 6-2-47 (Month) (Day) (Year)

(c) Place: burial or cremation:

18. (a) Signature of funeral director: W. Kirby

(b) Address: 3100 Rutgers

19. (a) JUN 2 1947 (Date received local registrar) (b) J. R. Bredicek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 31st year: 1947 hour: 6:05 minute: A.M.

21. I hereby certify that I attended the deceased from: 5/26/47, 19..., to: May 31st, 1947, 19...; that I last saw him alive on: May 31st, 1947, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage into lungs & Focal Atelectasis of lungs

Due to:

Due to:

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

Major findings: Of operations:

Of autopsy:

Duration

PHYSICIAN — Underline the cause of 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: [illegible] (M. D. or other)

Address: 1515 Lafayette Date signed:

Jefferson City Printing Co. (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.....

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.