

FILED JUN 21 1948

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

21256

Registration District No. **318**Primary Registration District No. **1003**Registrar's No. **5323**

## 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:  
CITY HOSPITAL 0  
 (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 NAMELOTTIE REED3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W. 6. (a) Single, widowed, married,  
divorced WIDOW6. (b) Name of husband or wife JACOB A. REED 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased AUGUST 8 1870  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
77 10 1 hr. min.9. Birthplace ALTON ILLINOIS  
(City, town, or county) (State or foreign country)10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

12. Name UNK BREWER13. Birthplace unknown UNK 9  
(City, town, or county) (State or foreign country)14. Maiden name unknown unknown15. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)16. (a) Informant M. Darcy(b) Address 1852 S. 12th St17. (a) BURIAL (b) Date thereof JUNE 11-48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation ST. MATTHEWS CEM(d) Signature of funeral director E. J. Schurer(b) Address 3125 Lafayette Ave19. (a) JUN 11 1948 (b) J. F. Bredenk  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County MOO  
 (c) City or town ST. LOUIS 17  
 (If outside city or town limits, write "RURAL") 9  
 (d) Street No. 2757 RUSSELL 9  
23 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9  
year 1948 hour 4 minute 45 A.M.21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Lobar Pneumonia; *Duration*  
fracture of right femur; when she  
fell out of bed while a patient at  
Malcolm Bliss Hospital on May 28,  
1948, about 1:00 o'clock A.M.  
ACCIDENT.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_ *Physician*  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) Accident(b) Date of occurrence 5-28-1948 *070*(c) Where did injury occur? St. Louis, Mo.  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Malcolm Bliss Hospital  
(Specify type of place)While at work? NO (Means of injury see above)23. Signature Patrick C. Taylor, Dep Cor (M.D. or other)Address 1300 Clark 2 Date signed 6-11-48

*Jm*

---

---

**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

*Jon B. Vollmer*

Licensed Embalmer No.

*4014*

P. O. Address

*3125 Lafayette Ave*

**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.**