

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10552  
2999

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>4229 E. Aldine St.,</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u> c. LENGTH OF STAY (In this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4229 E. Aldine St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis,</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis,</u> d. STREET ADDRESS (If rural, give location) <u>4229 E. Aldine St.,</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Henry</u> c. (Last) <u>Reed</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 31, 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12/24/1883</u>	
9. AGE (In years last birthday) <u>65</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mounds, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William Reed</u>		13b. MOTHER'S MAIDEN NAME <u>Lonie Collins</u>		14. NAME OF HUSBAND OR WIFE <u>Rose Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rose Reed 4229 E. Aldine St.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Branchopneumonia (terminal)</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Branchiectasis</u> DUE TO (c) <u>106</u> II. OTHER SIGNIFICANT CONDITIONS <u>52 1/2 X</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) - (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 24</u> , 19 <u>49</u> , to <u>Mar 31</u> , 19 <u>49</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Leah Smart MD</u> (Degree or title)				23b. ADDRESS <u>4069 1/2 Eastern Ave</u>		23c. DATE SIGNED <u>Apr 14, 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/4/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>APR 2 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>G. Wade Granberry 4202 Finney Ave</u>			

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

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.....

~~Student Embalmer No.~~.....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Leroy H. Pannister

Licensed Embalmer No. 4523

P. O. Address 3880 Easton 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.