

S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18970

State File No.

XC 1 964 362
Reg. 101,920

~~DECEASED~~ BIRTH NO. MAY 17 1952

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1233

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFF. BRKS. MO.		c. LENGTH OF STAY (in this place) 3 DAYS	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPARTA		d. STREET ADDRESS (If rural, give location) RR #1	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) E. c. (Last) REID			4. DATE OF DEATH (Month) (Day) (Year) 5-9-52
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/7/93
9. AGE (In years last birthday) 59 yrs.		10. KIND OF BUSINESS OR INDUSTRY PLUMBING	11. BIRTHPLACE (City and State or Foreign Country) SPARTA, ILLINOIS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JAMES REID		13b. MOTHER'S MAIDEN NAME LYDIA HOLBROOK	
14. NAME OF HUSBAND OR WIFE VIOLA REID		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. 361-09-8589⁰⁰		17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRO VASCULAR ACCIDENT ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIO VASCULAR DISEASE DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT (Specify) NONE	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) V.A.		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>5/7</u> , 19 <u>52</u> , to <u>5-9-52</u> , 19 <u> </u> , and that death occurred at <u>2:15^a</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <i>Herbert R. Donke</i> (Degree or title) M.D.		23b. ADDRESS V.A. HOSPITAL JEFF. BRKS. MO.	
23c. DATE SIGNED 5-9-52		24a. BURIAL CREMATION REMOVAL (Specify) EMERALD	
24b. DATE May 11		24c. NAME OF CEMETERY OR CREMATORY UNKNOWN Caladoma Sparta	
24d. LOCATION (City, town, or county) (State) Sparta, Randolph, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. P. Eider</i>	
25. FUNERAL DIRECTOR'S ADDRESS Sparta, Ill.		DATE REC'D BY LOCAL REG. 5-9-52	
REGISTRAR'S SIGNATURE <i>Herbert R. Donke</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. P. Eider</i>	

(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.....

..... Student Embalmer No.

..... working under my personal supervision.

Student
Student Embalmer

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.

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