

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 26 1953

State File No. 7875

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1672

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 3 days		e. STREET ADDRESS (If rural, give location) 14 5323 Delore Ave. 2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Park Lane Hospital		3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) R c. (Last) REED	
4. DATE OF DEATH: Febr. 10, 1953		5. SEX M 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 7-9-1870		9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months 7 Days 1 IF UNDER 1 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (City and State or Foreign Country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown Reed		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Irene Reed		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y or N, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Lost		17. INFORMANT'S SIGNATURE OR NAME Irene Reed, above; ADDRESS	

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) Hypertensive cardiovascular disease. Chronic myocarditis. INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Cardiac enlargement.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No surgery.		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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> - NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443 X	
22. I hereby certify that I attended the deceased from 2-8-53, 10 p/m to 2-10-53, that I last saw the deceased alive on 2-10-53, and that death occurred at 3:15 m., from the causes and on the date stated above.					

23a. SIGNATURE (Degree or title) M.D.		23b. ADDRESS 4930 Lindell Blvd., St. Louis, Mo.		23c. DATE SIGNED 2-12-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-13-53		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL HEALTH DEPT. REG. FEB 13 1953		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith, Maplewood, Mo. ADDRESS	
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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.....
Signature of Student Embalmer

Signed..... *J.P. Burgess*

Licensed Embalmer No. *40*

P. O. Address *Maple*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.