

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14391**
 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **545** Registrar's No. **903**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maplewood</b>		c. CITY OR TOWN <b>Maplewood</b> <b>7547</b>	
c. LENGTH OF STAY (in this place) <b>45 Yrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>7332 Maple Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>7332 Maple Ave.</b>	

3. NAME OF DECEASED (Type or Print) <b>EDWIN ATWOOD REED</b>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH <b>4-14-1954</b>	(Month) (Day) (Year)
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2-21-1870</b>	9. AGE (In years last birthday) <b>84</b>	10. UNDER 1 YEAR Months	11. UNDER 4 HRS. Hours	12. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mechanical</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Plympton Mass.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Joseph Reed</b>	13b. MOTHER'S MAIDEN NAME <b>Mary C Pfinney</b>	14. NAME OF HUSBAND OR WIFE <b>Louise B Reed</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs E.A. Reed</b>	ADDRESS <b>7332 Maple Ave.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic heart disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> 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 <b>4200</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Sept., 19 53, to Nov. 13, 19 53, that I last saw the deceased alive on Nov. 13, 19 53, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>J. A. Reed</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>19 E. Lockwood Ave., Webster Groves, 19, Mo.</b>	23c. DATE SIGNED <b>4-16-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	24b. DATE <b>4-17-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
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DATE REC'D BY LOCAL REG. <b>4-16-54</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donker</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Parker-Aldrich</b>	ADDRESS <b>F. Home Webster Groves</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Leslie Welch*

Licensed Embalmer No. *439*

P. O. Address *Water Street*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.