

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3325

FILED FEB 9 1955

State File No. \_\_\_\_\_

No. 300  
10.48

|   |  |  |  |   |   |  |   |  |  |
|---|--|--|--|---|---|--|---|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>317</u>  |  | PRIMARY REG. DIST. NO. <u>541</u>   |   | Registrar's No. <u>218</u>   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST. LOUIS</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u> |   |  |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>CLAYTON</u>   |  | c. LENGTH OF STAY (in this place) <u>D.O.A.</u>  |  | c. CITY OR TOWN <u>PINE LAWN</u>  |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>D.O.A. COUNTY HOSPITAL</u>   |  |  |  | e. STREET ADDRESS (If rural, give location) <u>2145 DAKDALE</u>   |   |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>JOHN</u>  |  |  | a. (First)                                     |   | b. (Middle) <u>REID</u>   |  | c. (Last)                               |  |  |
| 4. DATE OF DEATH <u>JAN 27 1955</u>   |  |  | (Month)  |   | (Day)   |  | (Year)                                  |  |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>   |   | 8. DATE OF BIRTH <u>OCT 16 1876</u>  |   | 9. AGE (In years last birthday) <u>78</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICKLAYER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK CONTRACTOR</u>  |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS MO</u>  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |  |
| 13a. FATHER'S NAME <u>JOHN REID</u>   |  |  | 13b. MOTHER'S MAIDEN NAME <u>ANN (UNKNOWN)</u> |   |   | 14. NAME OF HUSBAND OR WIFE <u>NONE</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. <u>NONE</u>            |   | 17. INFORMANT'S SIGNATURE OR NAME <u>Letitia Davis</u> ADDRESS <u>4060 JUNIATA</u>      |  |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)   |  | MEDICAL CERTIFICATION  |  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>UNKNOWN NATURAL CAUSES</u></p> <p>ANTECEDENT CAUSES</p> <p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p> |  |  |  |   |   |  |   |  |  |
|   |  |  |  |   |   |  |   |  |  |
|   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |   |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)   |   | 7955   |   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 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 _____, 19____, to _____, 19____, 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>Herbert R. Donke</u> (Degree or title) <u>M.D. Local Registrar</u>  |  |  |  | 23b. ADDRESS <u>651 S. Brentwood Blvd.</u>  |   |  | 23c. DATE SIGNED <u>2-1-55</u>          |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>  |  | 24b. DATE <u>JAN 31 1955</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>   |   | 24d. LOCATION (City, town, or county) (State) <u>St Louis Mo.</u>  |   |  |  |
| DATE REC'D BY LOCAL REG. <u>1-28-55</u>   |  | REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>   |  |   | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Callen Kelly</u> ADDRESS <u>7267 NATURAL BRIDGE</u> |  |   |  |  |

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

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**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 *Ben J. [Signature]*

Licensed Embalmer No. *4366*

P. O. Address *St. Louis*

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.