

FILED APR 14 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10093

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State File No. 2963  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place) <b>4 Days</b>	c. CITY OR TOWN <b>St. Louis, Mo.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>			STREET ADDRESS (If rural, give location) <b>520 Hickory</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>DELORES</b> b. (Middle) <b>JEAN</b> c. (Last) <b>REED</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 31, 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>11-8-1945</b>		9. AGE (In years last birthday) <b>9</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Oscar Reed</b>		13b. MOTHER'S MAIDEN NAME <b>Hattie Guthrie</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Oscar Reed, 520 Hickory Street.</b>		
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) <b>Pneumococcal meningitis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
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) _____		
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? <b>3401</b>		
22. I hereby certify that I attended the deceased from <b>3-29-55</b> , 19____, to <b>3-31-55</b> , 19____, that I last saw the deceased alive on <b>3-31-55</b> , 19____, and that death occurred at <b>5:55A</b> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Nancy A. Davis, M.D.</b>			23b. ADDRESS <b>1515 LAFAYETTE</b>		23c. DATE SIGNED <b>3-31-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4-2-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Churchyard</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>APR 1 1955</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLaughlin F.H., Inc. 2301 Lafayette</b>	

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..... *James R. Chapman*

Licensed Embalmer No. *45*

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.