

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 1560

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>CLAYTON</u> | | c. CITY OR TOWN <u>FENTON</u> | |
| c. LENGTH OF STAY (In this place) <u>2 Days</u> | | 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 <u>St Louis Co Hosp.</u> | | STREET ADDRESS (If rural, give location) <u>NONE</u> | |

| | | | | | |
|--|--|--|---|--|--|
| 3. NAME OF DECEASED a. (First) <u>FRANCES</u> b. (Middle) <u>Reid</u> c. (Last) <u>Reid</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>7-7-55</u> | | |
|--|--|--|---|--|--|

| | | | | | | | | | | | | | | | | | | | |
|-------------------|--|-------------------------------|--|---|--|----------------------------------|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 5. SEX <u>FEM</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>6-6-1895</u> | | 9. AGE (In years, last birthday) <u>60</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
|-------------------|--|-------------------------------|--|---|--|----------------------------------|--|--|--|---|--|---|--|---|--|--|--|---|--|

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| 13a. FATHER'S NAME <u>MORRIS DIXSMORE</u> | | | 13b. MOTHER'S MAIDEN NAME <u>ANNIE SHANE</u> | | | 14. NAME OF HUSBAND OR WIFE <u>FRED REID</u> | | |
|---|--|--|--|--|--|--|--|--|

| | | | | | | | |
|---|--|-------------------------------------|--|--|--|---------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>FRED REID</u> | | ADDRESS <u>FENTON, Mo</u> | |
|---|--|-------------------------------------|--|--|--|---------------------------|--|

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|----------------------------------|--|
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | 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. | | | | | | | |

| | | | | | | | | | |
|------------------------|--|----------------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | | 20. AUTOPSY? YES <input checked="" 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) <u>332X</u> (COUNTY) (STATE) | |
|--|--|--|--|---|--|

| | | | | | |
|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 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 7-5, 1955, to 7-7, 1955, that I last saw the deceased alive on 7-7, 1955, and that death occurred at 8:30A m., from the causes and on the date stated above.

| | | | | | |
|---|--|------------------------------------|--|--------------------------------|--|
| 23a. SIGNATURE <u>Joseph P. Ernst</u> (Degree or title) <u>M.D.</u> | | 23b. ADDRESS <u>6019 Brentwood</u> | | 23c. DATE SIGNED <u>7-8-55</u> | |
|---|--|------------------------------------|--|--------------------------------|--|

| | | | | | | | |
|--|--|--------------------------|--|---|--|---|--|
| 24a. BURIAL CREMATION REMOVAL (Specify) <u>REMOVED</u> | | 24b. DATE <u>7-11-55</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER & PAUL</u> | | 24d. LOCATION (City, town, or county) (State) <u>St Louis, Mo</u> | |
|--|--|--------------------------|--|---|--|---|--|

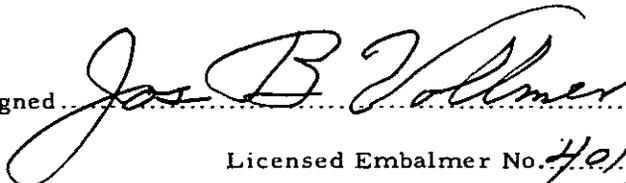
| | | | | | | | |
|--|--|--|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. <u>7/8/55</u> | | REGISTRAR'S SIGNATURE <u>Herbert R. Donker, MD</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schum</u> | | ADDRESS <u>3125 LA FAYETTE ST. LOUIS, MO</u> | |
|--|--|--|--|---|--|--|--|

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.....


Licensed Embalmer No. 401

P. O. Address 3/25/79

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.