

X Health,
& Welfare
Public
Service

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46240
STATE FILE NUMBER
11707

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

5. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital</i>		Length of stay in lb <i>17</i>	d. STREET ADDRESS <i>3839 McRee</i>
3. NAME OF DECEASED (Type or print) First <i>Fay</i> Middle Last <i>Reed</i>			4. DATE OF DEATH Month <i>12</i> Day <i>5</i> Year <i>57</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 4 1904</i>
9a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Sales lady</i>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <i>53</i>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (City and state or country) <i>Illinois</i>
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Joseph Reed</i>		13b. MOTHER'S MAIDEN NAME <i>Fairgina Reed</i>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>488-50-5616</i>		17. INFORMANT Address <i>Mrs. Gladys Burke 3839 McRee</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hemothorax, bilaterally;</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) <i>Multiple Fractures;</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <i>suffered when run over by</i>			
20a. 'ACCIDENT' SUICIDE' HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II if item 18)	
20c. TIME OF INJURY Hour <i>11:44</i> a.m. Month, Day, Year <i>12 5 57</i>		<i>about 11:44 a.m., December 5th 1957.</i>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>25 Street</i>	
20f. CITY, TOWN, OR LOCATION <i>St. Louis</i>		COUNTY <i>Mo.</i> STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <i>1155 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Patrick E. Taylor Carmel</i> (Degree or title)		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>12.6.57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>12/6/57</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cune Illinois</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <i>Jos. A. Howard</i> ADDRESS <i>1619 So. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>DEC. 6 '57</i>	
26. REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>		MO <i>mfs</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Robert M. Murray*
3749

Licensed Embalmer No.
P. O. Address *St. Louis, Mo*

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.