

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035051
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2423

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Berkeley		c. CITY OR TOWN Berkeley 4091	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6019 Jackson Ave.		d. STREET ADDRESS (If outside, give location) 6019 Jackson Ave.	
Length of stay in lb 2 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First William Middle Lloyd Last Reed			4. DATE OF DEATH Month 9 Day 18 Year 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-94	9. AGE (In years and birthday) 63	IF UNDER 1 YEAR Months 0 Days 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Polisher	10b. KIND OF BUSINESS OR INDUSTRY National Rej. Co.	11. BIRTHPLACE (City and state or country) Raleigh, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	--

13a. FATHER'S NAME Theodore C. Reed	13b. MOTHER'S MAIDEN NAME Augusta E. Bishop	14. NAME OF HUSBAND OR WIFE Mathel Reed
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I	16. SOCIAL SECURITY NO. 493-05-2110	17. INFORMANT Address S. C. Reed 6042 Washington Ave.
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overdose of Strychnine		INTERVAL BETWEEN ONSET AND DEATH July 18-58 9-18-58
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) 163X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour 8:00 Month 7 Day 18 Year 58 a.m. PM	

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.)	20f. CITY, TOWN, OR LOCATION ST. LOUIS	COUNTY ST. LOUIS	STATE MISSOURI
--	--	--	----------------------------	--------------------------

21. I attended the deceased from **7-18-58** to **9-18-58** and last saw her alive on **9-18-58**
Death occurred at **8:00 PM** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS 40 N. Florissant Rd.	22c. DATE SIGNED 9-18-58
--------------------------------------	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-22-58	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
--	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS White-Mullen 118 N. Florissant	25. DATE RECD. BY LOCAL REG. 9-21-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 _____

Eleanora Province

Licensed Embalmer No. 3403

P. O. Address Janney

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.