Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

58-046198
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12452

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b: 27

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4004 Delmar — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Julia — Middle: — Last: Reed (Oliver)

4. DATE OF DEATH: Month 12 Day 21 Year 58

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ 3 DIVORCED ☒
8. DATE OF BIRTH: 2-15-07
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months 10 Days 6 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Fort Smith Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: James S. Reed
13b. MOTHER'S MAIDEN NAME: Peggy Kane
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)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert Reed — Address: 6406 Eggleston, Chicago, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 260 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Coronary Insufficiency -, Diabetic Retinopathy with Blindness
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-1-58, to 12-21-58 and last saw her alive on 12-21-58
Death occurred at 5:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE F. O. Richards (Degree or title) M.D.
22b. ADDRESS: 2601 Whittier Street
22c. DATE SIGNED: 12-23-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12-29-58
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson Cemetery
23d. LOCATION (City, town, or county): St. Louis Co. (State): Mo.

24. FUNERAL DIRECTOR: Pettis Funeral Home — ADDRESS: 4181 Washington
25. DATE RECD. BY LOCAL REG.: DEC 24 '58
26. REGISTRAR'S SIGNATURE: Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Esther D. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Wash

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.