Health, & Welfare Public Service

300
1-57

95

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011302
STATE FILE NUMBER

APR 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2925

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DOA City Hospital — Length of stay in 1b 3	d. STREET ADDRESS (If outside, give location) 5325 N. Kingshighway — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: MAUDE	Middle: C.	Last: REAGEN	4. DATE OF DEATH Month: Mar. Day: 20 Year: 1959
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: June 9, 1893
9. AGE (In years last birthday): 65	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): housework	10b. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (City and state or country): Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: James Chitwood	13b. MOTHER'S MAIDEN NAME: Elizabeth Heflen	14. NAME OF HUSBAND OR WIFE: Wm. P. Reagen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT Address: Wm. P. Reagen 5325 N. Kingshighway	

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) Coronary Occlusion

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Coronary Sclerosis

DUE TO (c) 420.1

INTERVAL BETWEEN ONSET AND DEATH

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 [ ] NO [X] 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 _____ to _____ and last saw her/him alive on _____

Death occurred at 7:25 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] Deputy Coron 3	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 3/23/59	
23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: 3/24/59	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis (State) Mo.
24. FUNERAL DIRECTOR ADDRESS: Buchholz Mortuary 5967 W. Florissant	25. DATE RECD. BY LOCAL REG.: MAR 23 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.	

(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 .....

Licensed Embalmer No. 1551 .....

P. O. Address .....

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.