ealth,
Welfare
ublic
ervice

300
-57

77

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-023674
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1557

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Webster Groves — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 654 Marshall — Length of stay in 1b 31 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Webster Groves 4577 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 654 Marshall — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last REED
4. DATE OF DEATH Month Day Year June 7, 1959

5. SEX M
6. COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 3-19-1888
9. AGE (In years last birthday) 71 — 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) Carpenter-Builder
10b. KIND OF BUSINESS OR INDUSTRY Own account
11. BIRTHPLACE (City and state or country) Fiddle Creek, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Monroe Reed
13b. MOTHER'S MAIDEN NAME Unknown Pohlig
14. NAME OF HUSBAND OR WIFE Lucinda Glandt Reed

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. 493-10-6146
17. INFORMANT Lucinda Reed, Address above

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) Unknown Natural Causes — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7954
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

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 12:53A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John C. Murphy MD Acting Health Commissioner 801S.Brentwood Clayton,Mo.
22b. ADDRESS
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 6-10-59
23c. NAME OF CEMETERY OR CREMATORY City Cemetery
23d. LOCATION (City, town, or county) (State) Pacific, Mo.

24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH, Maplewood, Mo.
25. DATE RECD. BY LOCAL REG. 6-8-59
26. REGISTRAR'S SIGNATURE John C. Murphy 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 ....J. Allen Davis Jr.....

Licensed Embalmer No. 4053

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.