

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048677

318

1003

11963

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED DEC 21 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY - - -		a. STATE Mo. b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in lb 1 day	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarinate Word Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4467 S. 38th Street
3. NAME OF DECEASED (Type or print) A/K/A First Foster F. Reed Middle F.F. Reed last Foster Fernando Reed		4. DATE OF DEATH Month December Day 11, Year 1962	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1884
9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self employed		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (City and state or country) Bloomfield, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Peter Reed		13b. MOTHER'S MAIDEN NAME Amanda Baker	14. NAME OF HUSBAND OR WIFE Grace Reed
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address Mrs. Grace M. Reed 4467 S 38th St.
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Chronic cardiac failure			2 months
DUE TO (b) rheumatic heart disease			15 yrs.
DUE TO (c) cardiac hypertrophy			416x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m.	Month, Day, Year _____		
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	COUNTY STATE
21. I attended the deceased from 1-7-1946 to 12-11-62 and last saw ^{first} him alive on 12-10-62 Death occurred at 9:05 a.m. 12-11-62 on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edwin P. Scott, M.D.		22b. ADDRESS 3258 Lafayette St. St. Louis, Mo.	22c. DATE SIGNED 12-12-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-14-62	23c. NAME OF CEMETERY OR CREMATORY Laurel Hills Memorial	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY	ADDRESS SAM	25. DATE RECD. BY LOCAL REG. DEC 13 1962	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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Dr. Elwin P. Scott
318 Lafayette
PA 1-0064

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 Bill C. Brunson

Licensed Embalmer No. 4964

P. O. Address St Louis

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.