

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2762-63-009253

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY                                       |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>  |   | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>BETHESDA Hosp</u>  |   | d. STREET ADDRESS (If outside, give location)<br><u>2806 LAFAYETTE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>OLIVE</u> Middle <u>REEDS</u> Last   |   | 4. DATE OF DEATH<br>Month <u>MAR</u> Day <u>8</u> Year <u>63</u>  |   |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>SEPT 9, 03</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CASHIER</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STROBER FULLER</u>  | 11. BIRTHPLACE (City and state or country)<br><u>ILL.</u>   |
| 13a. FATHER'S NAME<br><u>ORRIN BROWN</u>   |   | 13b. MOTHER'S MAIDEN NAME<br><u>ELLA HAAS</u>   | 14. NAME OF HUSBAND OR WIFE<br><u>EDWIN C. REEDS</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><u>EDWIN C. REEDS</u> Address <u>2806 LAFAYETTE</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Diabetes Mellitus +</u>  |   |   | <u>Support</u>  |
| DUE TO (c) <u>Rheumatic H. Disease</u>   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>260+</u>   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <u>12/21/62</u> to <u>3/8/63</u> and last saw her <u>alive</u> on <u>3/8/63</u><br>Death occurred at <u>7:50 PM.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>M. de la B. Bance</u>   |   | 22b. ADDRESS<br><u>4665 Maryland</u>  | 22c. DATE SIGNED<br><u>5/9/63</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>  | 23b. DATE<br><u>MAR-12-63</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ALEXANDRIA CEM</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>ALEXANDRIA Mo</u>   |
| 24. FUNERAL DIRECTOR<br><u>KUTIS</u> ADDRESS <u>2906 PRAVOIS</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>MAR 9 1963</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith, M.D.</u>  |

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Dr. Malcolm Sweet

Walter Macfarland

**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 *Carly H. Hays*  
Licensed Embalmer No. 4801

P. O. Address St. Louis 19 Mo

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.