

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022118

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

5448

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 3 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

91

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>20 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>E/R to City Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4213 Cleveland</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES HENSLEY REEVES</b>			4. DATE OF DEATH Month Day Year <b>May 17, 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/79</b>
9. AGE (last birthday) <b>84</b>		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) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Tenn.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. NAME OF HUSBAND OR WIFE <b>Norma Reeves</b>	
13a. FATHER'S NAME <b>Ephriem Reeves</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Lay</b>	
14. NAME OF DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		15. SOCIAL SECURITY NO.	
<b>No</b>		16. INFORMANT Address <b>Loretta Schaefer, 3935 Castlemans, St. Louis</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>420.0</b>			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)			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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>5:40 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Paul J. Demin Deputy Coroner</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>5/22/63</b> (Stamp)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/22/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin, 2301 Lafayette, St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 22 1963</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>

**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,

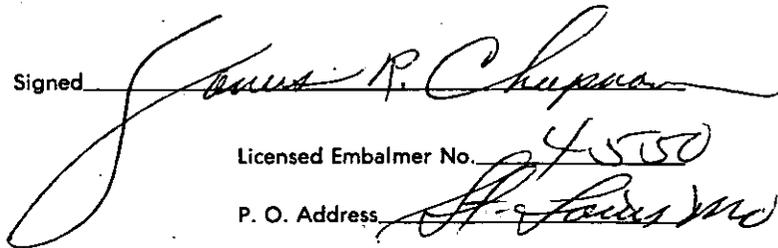
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 45550

P. O. Address St. Louis 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.