

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046545
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 330

FILED NOV 20 1963

VS 300
Rev. 4/59

14002

2400X

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

| | | | | | | |
|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST. LOUIS | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON'S CORPUS HOSP. | | Length of stay in 1b 1 WEEK | c. CITY OR TOWN OVERLAND 14 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CO., HOSP. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 10595 RIDGE AVE., | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jess Middle LBE Last Reeder | | | 4. DATE OF DEATH Month 10 Day 26 Year 63 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-23-1890 | 9. AGE (last birthday) 73 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10b. KIND OF BUSINESS OR INDUSTRY McDonnell Aircft. | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME Daniel Reeder | | 13b. MOTHER'S MAIDEN NAME Elizabeth Lundsford | | 14. NAME OF HUSBAND OR WIFE GOLDEN M. REEDER | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of) No. | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Golden M. Reeder-10595 Ridge Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia | | | | | 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) Parotitis, Generalized arteriosclerosis | | | | 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 <u>10-19-63</u> to <u>10-26-63</u> and last saw ^{be-} him alive on <u>10-26-63</u> Death occurred at <u>10:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22. SIGNATURE <i>John M. Carner, M.D.</i> | | 22b. ADDRESS <u>6015 S. Brentwood Clayton Mo</u> | | 22c. DATE SIGNED | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 10-30-1963 | 23c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery | 23d. LOCATION (City, town, or county) (State) Bridgeton, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS BAUMANN BROS. INC. 2504 WOODSON RD. OVERLAND 14, MO. | | 25. DATE RECD. BY LOCAL REG. 10-28-63 | 26. REGISTRAR'S SIGNATURE <i>John M. Carner</i> | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

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

David C. Gibson

Licensed Embalmer No. 3454

P. O. Address St. L, 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.