

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0051046

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 13005

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED 23 64

VS 300
Rev. 4/59

1

2 2/3

3

4 0

5 1

6

7 1

8 1

9

10

11

12 75-3

13

75

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF DATE AMENDED)

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>39 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital #1</u>		d. STREET ADDRESS (If outside, give location) <u>4942a Odell A e.</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JASPER DATHORD REID</u>			4. DATE OF DEATH Month Day Year <u>Dec. 29, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-84</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	11. BIRTHPLACE (City and state or county) <u>Shelbyville, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James Reide</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Pifer</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>4942a Odell Mrs. Minnie Reid, St. Louis, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Volcanus of Small Intestine with</u> <u>Massive Hemorrhage</u> DUE TO (b) <u>Branchopneumonia bilateral</u> DUE TO (c) <u>570.3</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (e)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		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	
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 _____ <u>10:01 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degrees or Title) <u>Paul Simon</u>		22b. ADDRESS <u>1300 Clark</u>	
22c. DATE SIGNED <u>12/30/63</u> (State)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>12-31-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mathews Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>John J. Kassly, E. St. Louis, Ill.</u>	
25. DATE RECD. BY LOCAL REG. <u>DEC 30 1963</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>	

1301300
- 00001

AMT 11 23 66

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 John J. Kessler

Licensed Embalmer No. 5039

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.