N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39703
Do not use this space.

1. PLACE OF DEATH 13 1937 Homer G Phillips Hospital
   (a) County ..... Registration District No. 791
   (b) Township ..... Primary Registration District No. 1003 Registered No. 10690
   (c) City St. Louis (d) Street No. 2601 N Whittier St.
   (If death occurred in Hospital or Institution, write its name instead of street and number)
   (e) Length of residence in city or town where death occurred 11 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Reeves
   (a) Residence, No. 803a N. 20th St. 21
   (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	C	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ------

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 9, 1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	48	3	4	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charleston Miss.

FATHER
13. NAME Henry Reeves
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

MOTHER
15. MAIDEN NAME Kassie Jones
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

17. INFORMANT (ADDRESS) Evelyn Hilliard 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL
PLACE Father Dicksons DATE Nov. 19 / 1937

19. FUNERAL DIRECTOR (ADDRESS) E. L. Garner 2829 Washington Ave.

20. FILED NOV 19 1937 J F Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 13 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1937, to Nov. 13, 1937
I last saw him alive on Nov. 13, 1937. Death is said to have occurred on the date stated above, at 5:20 m. a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Embolism, non tubercular	10/27/37
Carcinoma of Rectum ~~non-tubercular~~	

Other contributory causes of importance: 46 D

Name of operation ..... Date of .....
What test confirmed diagnosis? clinic Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) J M Walker Jr, M. D.
(Address) 2601 N Whittier

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Arthur L. Hellbaid, Licensed Embalmer No. 3389

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Arthur L. Hellbaid

Licensed Embalmer No. 3389

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)