

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.

BUREAU OF THE CENSUS
SEP 14 1939

State File No. _____

Registration District No. 791

Primary Registration District No. _____

Registrar's No. 7566

1. PLACE OF DEATH: 1003

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days)

In this community 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")

(d) Street No. 1815 N 20th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years

3. (a) PRINT FULL NAME Jesse Reagan 250

3. (b) If veteran, name war _____

3. (c) Social Security No. 489-03-164

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rona Regen REAGAN

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Feb. 7, 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

38	6	23	hr. min.
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9. Birthplace Carbondale, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer

11. Industry or business Nut Co.

MOTHER FATHER

12. Name James Reagan

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Don C. Know

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jesse Reagan

(b) Address 1815 N 20th St.

17. (a) Removal (b) Date thereof Sept. 1/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Piedmont, Mo.

18. (a) Signature of funeral director Wm. B. ...

(b) Address 2201 S Grand Bl.

AUG 31 1939

19. (a) _____ (b) J. P. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30, year 1939 hour 5:25 minute A. M.

21. I hereby certify that I attended the deceased from August 23, 1939, to August 30, 1939; and that death occurred on the date and hour stated above.

that I last saw him alive on August 30, 1939

Immediate cause of death Cerebral Thrombosis
Left Hemiplegia

Due to CNS Syphilis

Due to _____

Other conditions [Signature]
(Include pregnancy within 5 months of death)

Major findings: [Signature]

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (Means of injury)

23. Signature Samuel ... (M. D. or other) MD

Address City Hospital #1 Date Signed 8/30/39

Duration 10 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Nancy Adkins

Licensed Embalmer No..... 3722

P. O. Address..... 412 Duchouquette St.

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 this body is not embalmed, above space should be left blank.