

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37979
Registrar's No. 9818

Registration District No. 791 Primary Registration District No. _____

1. PLACE OF DEATH: 1008
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 67 days
(Specify whether
In this community Unknown
years, months or days)

8. (a) PRINT FULL NAME Alonzo Reid
8. (b) If veteran, name war None
8. (c) Social Security No. 489-14-1879

4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 1. 1899
(Month) (Day) (Year)

8. AGE: Years 40 Months - Days 10
If less than one day hr. _____ min. _____

9. Birthplace Laudale Co. Miss
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER { 12. Name Ed Reid
13. Birthplace Miss
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Isabelle Bruster
15. Birthplace Miss
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Will Reid
(b) Address 3669 Finney Ave

17. (a) _____ (b) Date thereof 11-17-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis U. School of Me.

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St

19. (a) Nov 17 1939 (b) J. Bruster
(Date received and read) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 3321 Franklin Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 11
year 1939 hour 7:40 minute A. M.

21. I hereby certify that I attended the deceased from 9-6, 1939 to 11-11, 1939;
that I last saw h. im alive on 11-11, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease About 3 years
Due to Syphilis Unknown

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)
(e) Means of injury _____

23. Signature J. J. Lyman (M. D. or other)
Address 2001 N. Whittier St. Date signed 11-13-1939

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

L. Boykum
Amph...

Registered Apprentice No. _____

working under my personal supervision.

Signed *L. Boykum*
Licensed Embalmer No. *2946*
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 this body is not embalmed, above space should be left blank.

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

37979

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... **301**
 (b) Township..... Primary Registration District No..... **1008**
 (c) City..... (d) Street No..... 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **3324 FRANKLIN** St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF UNKNOWN			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)			
7. AGE	YEARS	MONTHS	DAYS
			If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
	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)			
FATHER	13. NAME		
	14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)		
MOTHER	15. MAIDEN NAME		
	16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)			
18. BURIAL, CREMATION, OR REMOVAL			
PLACE		DATE	
19. FUNERAL DIRECTOR (NAME) (ADDRESS)			
20. FILED 12/15 39 J. F. Brudeck Local Registrar			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-11-39**

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

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

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)....., M. D.
 (Address).....

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

50M-9-19-38
 I X10605

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.....

Licensed Embalmer No.....

P. O. Address.....

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.