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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
AUG 26 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

23627

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6072

**1. PLACE OF DEATH:**

(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 8 Days  
(Specify whether years, months or days)

In this community \_\_\_\_\_

8. (a) PRINT FULL NAME Bessie Reid 307

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

name war None No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife John McElroy Reid Jr. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 20, 1884  
(Month) (Day) (Year)

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

56	2	29	_____ hr. _____ min.
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9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business City Sanitarium

MOTHER FATHER

12. Name Unknown Keith

13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Hall

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Opal Papin

(b) Address 1221 Griefield Place

17. (a) Burial (b) Date thereof 7-22-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) JUL 20 1940 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis 13  
(If outside city or town limits, write "RURAL")

(d) Street No. 5300 Arsenal St.  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 19,  
year 1940 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from July  
11, 1940, to July 19, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cerebral thrombosis  
middle cerebral artery - left

Due to Hypertension?

Due to Atherosclerosis

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Cerebral hypoxia  
thrombosis

Duration 1 wk

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. Meony (M. D. or other) \_\_\_\_\_  
Address 2515 Lafayette Date signed 7/19/40

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

**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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.**