

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 15 1943 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 1986

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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
In this community 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 2739 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Charles Reed

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased. Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 60 hr. min.

9. Birthplace Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business Nil

12. Name Square Reed

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

14. Maiden name Unknown

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

16. (a) Informant Shirley M. Smith
(b) Address 2601 N. Whittier St.

17. (a) Interment (Burial, cremation, or removal) (b) Date thereof 2-4-43
(Month) (Day) (Year)
(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. ...
(b) Address 3880 ...

19. (a) MAR 1 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30, year 1943 hour 4 minute 05 P. M.

21. I hereby certify that I attended the deceased from January 21, 1943 to January 30, 1943; that I last saw him alive on January 30, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Auricular Fibrillation
Arteriosclerosis

Duration Unk.
Unk.

Due to.....

Due to.....

Other conditions 97
(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 St. P. Williams (M. D. or other) 0
Address 2601 Whittier Date signed 2/4/43

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

MOTHER FATHER

(Handwritten mark)

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, fact should be so stated above.