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State File No. ....

FILED JUN 1944  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5015**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
**Home r Phillips Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 days**  
(Specify whether years, months or days)

In this community **30 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. **1130 N. 20th St.**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Mable Reid**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **26**, year **1944** hour **11** minute **25** A.M.

4. Sex **Female** 5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased **Dec. 22 1884**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 16**, 19**44** to **May 26**, 19**44**; that I last saw her alive on **May 26**, 19**44**; and that death occurred on the date and hour stated above.

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

**59** **5** **4** hr. \_\_\_\_\_ min.

Immediate cause of death **Hypertensive Heart Disease**

Duration **Unk.**

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation **Housewife**

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business **None**

MOTHER FATHER { 12. Name **James Howard**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mildred Best**

(b) Address **1924 Biddle**

17. (a) **Burial** (b) Date thereof **6/2/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Father Dickson**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Mary Wade**

(b) Address **4202 E. Finney Ave**

19. (a) **JUN 1944** (b) **J. F. Brueck**  
(Date received from Registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury **0**

23. Signature **Alva Moore** (M. D. or other)  
Address **2601 Whittier** Date signed **5/29/44**

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.....

Licensed Embalmer No. *2698*

P. O. Address *2769 Waverly*

**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.**