

FILED JUL 31 1944

318

Primary Registration District No. **1003**

Registrar's No. **6365**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Saint 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 **3 hours**
(Specify whether
In this community **34-years**
years, months or days)

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

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **November 7, 1909**
(Month) (Day) (Year)

8. AGE: Years **34** Months **8** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **Saint Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **William H. Reid**

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

14. Maiden name **Willieanna**

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

16. (a) Informant **Anniebelle Reid**

(b) Address **2709 Locust Street,**

17. (a) **Burial** (b) Date thereof **7/20/1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Charles J. Gates**

(b) Address **4107 Finney Avenue**

19. (a) **JUL 19 1944** **J. F. Breaux**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Saint Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2709 Locust Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **14**
year **1944** hour **12** minute **15 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pulmonary Tuberculosis

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

Duration

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 **Thomas J. Callan** (M. D. or other) _____
Address **1302 Grand Boulevard** Date **7/19/44**

STATEMENT BY LICENSED EMBALMER

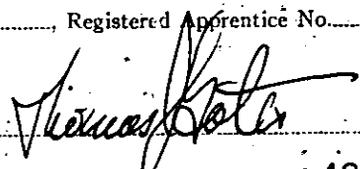
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

....., Registered Apprentice No.

working under my personal supervision.

Signed.....



Licensed Embalmer No. **4259**

P. O. Address **4107 Finney Avenue**

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.