S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

22459

State File No. 6750

FILED AUG 3 1945

Registration District No. 818 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County St Louis Mo.

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4443 Cottage Ave 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 30 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 000

(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")

(d) Street No. 4443 Cottage Ave 1 (If rural, give location)

(e) Citizen of foreign country? 0 (~~Yes or~~ No)

If yes, name country

3. (a) PRINT FULL NAME Donnie Reid

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex M 2

5. Color or race Col

6. (a) ~~Single, widowed~~, married, ~~divorced~~ 1

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 13 (Day) 1883 (Year)

8. AGE: 61 Years ~~02~~ Months 11 Days 18 If less than one day hr. min.

9. Birthplace Eolia Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Labor

11. Industry or business none

FATHER
12. Name Unknown
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Margrett Reid
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant Mrs. Reid

(b) Address 4443 Cottage

17. (a) (Burial, ~~cremation or~~ removal) (b) Date thereof 8 (Month) 1 (Day) 1945 (Year)

(c) Place: burial or cremation Eolia Mo.

18. (a) Signature of funeral director H. J. Smith

(b) Address 4247 W. Papadie Ave.

19. (a) JUL 31 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1945 hour 9:30 minute P M.

21. I hereby certify that I attended ~~the deceased~~ from 6/27 1945 to 7/27 1945 that I last saw him alive on 7/26 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral Insufficiency — Duration: 4 years

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92

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? (Specify type of place)

While at work (e) Means of injury

23. Signature Chas E. Kimmel (M. D. or other)

Address 4322 S Easton Date signed 7/29

(Licensed Embalmer's Statement on Reverse Side)

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 Lawrence E. Woodson, ~~Registered Apprentice No.~~ ....., working under my personal supervision.

Signed Pamela Johnson

Licensed Embalmer No. 3522

P. O. Address 3704 Finney Ave

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.