

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 52 days  
(Specify whether years, months or days)  
 In this community 53 years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County 000  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1280 Hamilton Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME REID, Joseph E.

3. (b) If veteran, name war World I. 3. (c) Social Security No. 347 01 3722

4. Sex Male 5. Color or race White 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 May 23 1892  
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
|         | 53    | 7      | 16   | hr. _____ min.       |

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

10. Usual occupation Salesman

11. Industry or business \_\_\_\_\_

12. Name John M. Reid

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

14. Maiden name Ruth Anne Reid

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

16. (a) Informant Clinical Clerk, Vet. Adm. Hosp.

(b) Address Jefferson Barracks, Missouri

17. (a) Burial (b) Date thereof 12-12-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary

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

(b) Address 3840 Lindell Blvd

19. (a) 12-12-45 (b) Ed M. Saran M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 8  
 year 1945 hour 4:40 minute P. M.

21. I hereby certify that I attended the deceased from October 17, 1945, to December 8, 1945, that I last saw him alive on December 8, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death CANCER OF RECTUM AND SIGMOID, FAR ADVANCED. Duration Unknown

Due to --

Due to --

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

Major findings: 1st. stage Resection (Colostomy). Nov. 28, 1945.

Of autopsy No autopsy.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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 \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. V. EDWARDS, Lt. Col., Clinical Director. (M. D. or other) M. C.

Address Vet. Adm. Hosp., Jeff. Bkks., Mo. Date signed 12/10/45

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

JAN 29 1945

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. 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, fact should be so stated above.