

FILED JAN 11 1945
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1130 Hodiament Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution _____
(Specify whether _____)
In this community _____
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 Hodiament Ave
(If rural, give location) 0.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Josiah E. Reid

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Laella Reid 6. (c) Age of husband or wife if alive Deceased
7. Birth date of deceased 8/18/1854
(Month) (Day) (Year)

8. AGE: Years 91 Months 3 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Blacksmith

MOTHER FATHER { 12. Name James R. Reid
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Espy
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Walter E. Reid

(b) Address 8116 Midland Ave

17. (a) Removal (b) Date thereof 12/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pana Illinois

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) DEC 27 1945 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 26
year 1945 hour 12:40 minute A.M.

21. I hereby certify that I attended the deceased from MARCH 13
1943 to DECEMBER 26 1945;
that I last saw h.l.h. alive on DECEMBER 20 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency Duration 6 mo.
Due to Chronic Myocarditis 5 YRS.

Due to Chronic Interstitial Nephritis 12 YRS

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 131

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? _____

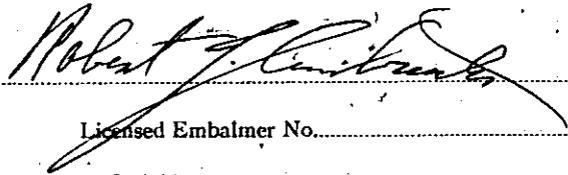
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature P. A. Barnick (M. D. or other) P. O.
Address 6651 Enright Ave Date signed 12/27/45

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.