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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42494

FILED DEC 28 1945

Registration District No. _____ Primary Registration District No. 6076 Registrar's No. 2842

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 59 days (Specify whether years, months or days)
In this community 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Normandy Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7332 Burkwood
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Roy Allen Reed
3. (b) If veteran, name war ?
3. (c) Social Security No. ?
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Gertrude E. Price Reed
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased December (Month) 23 (Day) 1894 (Year)

8. AGE: Years 50 Months 11 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace Labadie (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Advertising Representive
11. Industry or business —
FATHER
12. Name Benjamin F. Reed
13. Birthplace ? (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Mary Ellen Reed
15. Birthplace ? (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Hospital Record
(b) Address Koch Hosp.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) 12-17-45 (Date received local registrar) (b) E. S. McGannon M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14 year 1945 hour 10:46 minute P. M.
21. I hereby certify that I attended the deceased from October 16, 1945, to December 14, 1945 that I last saw h. alive on December 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	8 mo. ?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 Reinhold Engleman M.D. (M.D. or other)
Address Koch Hospital Date signed 12/15/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Albert R. Thompson Jr

Licensed Embalmer No. 4287

P. O. Address St. Louis

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.