

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

10660

FILED APR 1 1946

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 738

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Mary's Hospital
(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

3. (a) PRINT FULL NAME Baby Reid

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

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 March 23 1946
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>4</u>	hr. _____ min.

9. Birthplace Richmond Heights, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Roy W Reid

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

14. Maiden name Dorothy B. Mervelkamp

15. Birthplace St. Louis, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Roy W. Reid

(b) Address Ste. Genevieve, Mo.

17. (a) Burial (b) Date thereof 3-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve, Mo.

18. (c) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 3-29-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste Genevieve

(c) City or town Ste. Genevieve
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes, or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27 year 1946 hour 1:30 minute P M.

21. I hereby certify that I attended the deceased from 3-23-46 19. to 3-27-46 19. ;
that I last saw him alive on 3/27/46 19. ;
and that death occurred on the date and hour stated above.

Immediate cause of death obstruction due to atresia of colon.

Due to _____

Due to 157m

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

Major findings: Congenital atresia of colon.

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)

Means of injury _____

23. Signature Warren J. Maistron (M. D. or other): _____

Address 607 N. Grand Date signed 3/28/46

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

MOTHER, FATHER

757

NO EMBALM

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.