

3000
10-47
17-39
1 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38566**

FILED DEC 2 1948
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10063**

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME John P. Reeds

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Carrie Reeds 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 16 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>0</u>	<u>1</u>	hr. _____ min. _____

9. Birthplace Effingham Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Shoe Worker

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Walter Mudge

(b) Address 3528 So. Spring Ave.

17. (a) Burial (b) Date thereof 11-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

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

(b) Address 4700 Washington Blvd.

19. (a) NOV 20 1948 (b) J. B. Rosales
(Local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 3528 So. Spring
Memorial 16 (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17th
year 1948 hour 2 minute 05 P. M.

21. I hereby certify that I attended the deceased from 10/9/48
_____, 19____, to Nov. 17th 1948
that I last saw h. im. alive on Nov. 17th 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Reactions of the prostate with some metastases. 2 yr. pulmonary tuberculosis unknown Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy Calcium of prostate; pulmonary tuberculosis.

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 _____ Means of injury _____

23. Signature Frank J. Madon (M.D. or other) _____
Address 1515 Lafayette Date signed 11/17/48

Marie

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, ~~and~~ by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *Elton M. Remelick*

Licensed Embalmer No. *4293*

P. O. Address. *St. Louis, Mo.*

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.