FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JAN 18 1949

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42702

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11454

1. PLACE OF DEATH:

(a) County

(b) City or town StLouis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Hours (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. RFD 8
(If rural, give location)

UR

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

If yes, name country

3. (a) PRINT FULL NAME Carrie Ethel Gold Reid

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lewis

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Sept (Month) 18 (Day) 1888 (Year)

8. AGE: Years 60 Months 3 Days 5 If less than one day hr. min.

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

10. Usual occupation Waitress

11. Industry or business Cafe

FATHER
12. Name Silas Gold
13. Birthplace Billings (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Julia Hale
15. Birthplace Billings (City, town, or county) Missouri (State or foreign country)

16. (a) Informant E M Gold
(b) Address Billings.Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-48 (Month) (Day) (Year)
(c) Place: burial or cremation Billings. Missouri

18. (a) Signature of funeral director Rowland Mortuary Svc
(b) Address 4104 Manchester

19. (a) (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 23 day 23 year 1948 hour 3:40 minute P M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Gliosis of Brain; Cardiac Hypertrophy; Non-Malignant Tumor.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Patrick E Jung (M.D. or other)

Address Date signed 1/6/48

(Licensed Embalmer's Statement on Reverse Side)

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

11454

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.