

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3156**
172

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri				b. COUNTY B-0	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 4319 Warne Ave			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4319 Warne Ave				d. STREET ADDRESS 9				d. FULL NAME OF HOSPITAL OR INSTITUTION 4319 Warne Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Ray			b. (Middle) Clarence			c. (Last) Reed			
4. DATE OF DEATH (Month) (Day) (Year) Jan. 6, 1949			5. SEX Male			6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married			8. DATE OF BIRTH June 26, 1913			9. AGE (In years last birthday) 35			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Dazey Corp.			10b. KIND OF BUSINESS OR INDUSTRY Dazey Corp.			11. BIRTHPLACE (State or foreign country) Algona, Iowa			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME Clarence Eichinger			13b. MOTHER'S MAIDEN NAME Estelle G. Lambert			
14. NAME OF HUSBAND OR WIFE Anna Jane Reed			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. _____			
17. INFORMANT'S SIGNATURE OR NAME Anna Jane Reed			17. INFORMANT'S SIGNATURE OR NAME Anna Jane Reed			ADDRESS 4319 Warne Ave			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Paranoma lower sigmoid				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 8 mos	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paranoma lower sigmoid				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. H/O 1/3	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				19a. DATE OF OPERATION 6/17/48				19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H/O 1/3			
22. I hereby certify that I attended the deceased from May 17, 1948 , to Jan. 6, 1949 , that I last saw the deceased alive on Dec. 18, 1948 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above.									
23a. SIGNATURE J. P. Wilson M.D.				23b. ADDRESS 4020 W. Flouissant				23c. DATE SIGNED 1/7/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan 8, 1949		24c. NAME OF CEMETERY OR CREMATORY Earlville Cemetery		24d. LOCATION (City, town, or county) (State) Earlville, Iowa			
DATE REC'D BY LOCAL REG. JAN 7 1949				REGISTRAR'S SIGNATURE J. B. Losater				25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc.	
				ADDRESS 2161 East Fair					

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Walter G. Burnley*

Licensed Embalmer No. *4202*

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.