S. No. 300
v. 10.48

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

FILED AUG 20 1949

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 28462

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6967

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DePaul Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: one
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
d. STREET ADDRESS (If rural, give location): 5028 Wabada Ave.

**3. NAME OF DECEASED** (Type or Print)
a. (First): James
b. (Middle): S
c. (Last): REID

**4. DATE OF DEATH** (Month) (Day) (Year): August 9, 1949

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married
**8. DATE OF BIRTH**: July 27, 1905
**9. AGE** (In years last birthday): 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ironworker
**10b. KIND OF BUSINESS OR INDUSTRY**: Fruin Colnon.
**11. BIRTHPLACE** (State or foreign country): Springfield, Illinois
**12. CITIZEN OF WHAT COUNTRY?**:
**13a. FATHER'S NAME**: Alex Reid
**13b. MOTHER'S MAIDEN NAME**: Agnes Shanks
**14. NAME OF HUSBAND OR WIFE**: Mary C. REID
**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): Navy
(If yes, give war or dates of service): World War 2
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT'S SIGNATURE OR NAME**: Mary C. REID
ADDRESS: 5028 Wabada Ave.

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))

*This does not mean the mode of dying, such as heart failure, asthenia, etc., It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Coronary Sclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**:
**19b. MAJOR FINDINGS OF OPERATION**:
**20. AUTOPSY?** YES ☐ NO ☐

**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): 94a
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.:
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**: 420.1

22. *I hereby certify that I attended the deceased from* July 7, 1949, *to* Aug. 9, 1949, *that I last saw the deceased alive on* Aug. 7, 1949, *and that death occurred at* 10 p.m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Edwin B. Harvey M.D.
**23b. ADDRESS**: Humboldt Bldg St. Louis
**23c. DATE SIGNED**: 8/10/49

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: Aug. 10, 1949.
**24c. NAME OF CEMETERY OR CREMATORY**:
**24d. LOCATION** (City, town, or county) (State): Springfield Illino

DATE REC'D BY LOCAL REGISTRAR: AUG 10 1949
REGISTRAR'S SIGNATURE: [signature]
**25. FUNERAL DIRECTOR'S SIGNATURE**: [signature]
ADDRESS: 1389 Union Blv

(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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Signed Ronald Yahoke

Signed _____
Student Embalmer

Licensed Embalmer No. 7917

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.

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THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State of ..... } ss.
County of ..... }

**AFFIDAVIT FOR CORRECTION OF A RECORD**

State File No. 2846..
Local Registrar's No. 6967

On this ..... day of ....., 194....., before me appears .....
....., who, upon ..... oath, states that the original record of birth/death for James S. Redi, died/born 8-9-49, 19....., in the State of Missouri, and which was filed at ..... on ....., 19....., should be corrected as follows:

Item No. 3 should read James S. Reid
Instead of James Reid
Item No. 14 should read Mary C. Reid
Instead of Mary Reid
Item No. ..... should read .....
Instead of .....
Item No. ..... should read .....
Instead of .....
Item No. ..... should read .....
Instead of .....
Item No. ..... should read .....
Instead of .....
Item No. ..... should read .....
Instead of .....
Item No. ..... should read .....
Instead of .....

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Joseph M. Zuino Fun.
Relationship.

1389 Union Blvd.
Present Address.

Subscribed and sworn to before me this 20 day of Sept., 1949

My Commission expires My Commission Expires March 4th, 1953 Ella C. Paddock Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

V. S. 135
—8-43
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