

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35505

State File No. _____

FILED NOV 10 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9332**

1599

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis - 12	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2833 Stoddard		2833 Stoddard	

3. NAME OF DECEASED a. (First) ROYER b. (Middle) c. (Last) Reid		4. DATE OF DEATH (Month) (Day) (Year) 9 26 49	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Apr 1881
9. AGE (In years, if under 1 year list months) (Months) (Days) (Hours) (Min.) 68	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W.R.	10b. KIND OF BUSINESS OR INDUSTRY W.R.	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME W.R.	
13b. MOTHER'S MAIDEN NAME W.R.		14. NAME OF HUSBAND OR WIFE W.R.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give part of date of service) W.R.	16. SOCIAL SECURITY NO. W.R.	17. INFORMANT'S SIGNATURE OR NAME James E. Ryan ADDRESS 300 Clark	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last.		
	DUE TO (b) Pulmonary DUE TO (c) Tuberculosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Lobar Pneumonia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION W. M. A.	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 130
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Joseph M. ... (Degree or title)	23b. ADDRESS 1500 Clark	23c. DATE SIGNED 10/8/49
24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE OCT 31 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. OCT 31 1949	REGISTRAR'S SIGNATURE J. B. ...	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. ADDRESS
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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 Ralph W. Henson

Licensed Embalmer No. 3791

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.