

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21940
5530
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.
c. LENGTH OF STAY (in this place) 38 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri
b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 2129
d. STREET ADDRESS (If rural, give location) 780 a.N. Euclid Ave.

3. NAME OF DECEASED
a. (First) WALTER
b. (Middle) REED
c. (Last) REED

4. DATE OF DEATH (Month) (Day) (Year)
6 22 1950

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Dec 11, 1881

9. AGE (in years last birthday) 68

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) Porter

10b. KIND OF BUSINESS OR INDUSTRY Apartment Bldgs

11. BIRTHPLACE (State or foreign country) Coffeeville, Miss /

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Reed

13b. MOTHER'S MAIDEN NAME Elizabeth Fox

14. NAME OF HUSBAND OR WIFE Dead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 491-12-5145

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ophelia Reed 2709 N. Whittier Street.

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.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ARTERIOSCLEROTIC HEART DISEASE
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.

INTERVAL BETWEEN ONSET AND DEATH YEARS

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? H200

22. I hereby certify that I attended the deceased from 10-1-1948 to 6-21-1950, that I last saw the deceased alive on 6-21-1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert Shinn O.M.D.

23b. ADDRESS 601 BRENTWOOD, CLAYTON

23c. DATE SIGNED 6-23-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6/27/50

24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis, Mo

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 26 1950 J.B. Foster

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.W. Roberts 1416 N. Taylor Ave.

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Amiel Roberts

Signed.....
Student Embalmer

Licensed Embalmer No. 4439

P. O. Address 1416 N. Jay

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.