

FILED JUN 27 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22532
Registrar's No. 5071

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 4 yrs.		d. STREET ADDRESS (If rural, give location) 3953 St. Ferdinand Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) Douglas	a. (First)	b. (Middle)	c. (Last) Reed	4. DATE OF DEATH May 31 1952
--	------------	-------------	-------------------	---------------------------------

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/4/1910	9. AGE (In years last birthday) 41	10. MONTH 10	11. DAY 27	12. IF UNDER 1 YEAR Hours 10	13. IF UNDER 24 HRS Min. 27
----------------	---------------------------	---	------------------------------	---------------------------------------	-----------------	---------------	---------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver	10b. KIND OF BUSINESS OR INDUSTRY St. L. American	11. BIRTHPLACE (City and State or Foreign Country) Manure Co., Ga.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	-------------------------------------

13a. FATHER'S NAME Ed. Reed	13b. MOTHER'S MAIDEN NAME Mamie Anthony	14. NAME OF HUSBAND OR WIFE Lucille Reed
--------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Lucille Reed, 3953 St. Ferdinand	ADDRESS
--	-------------------------	---	---------

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, aneurism, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH Undet.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		
	DUE TO (c) None		
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 <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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X
--	--	------------------------------------

22. I hereby certify that I attended the deceased from 5-12, 1952, to 5-31, 1952, that I last saw the deceased alive on 5-31, 1952, and that death occurred at 9:30p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. Arneson, M.D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 6-2-52
--	------------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6/3/52	24c. NAME OF CEMETERY OR CREMATORY Augusta, Georgia	24d. LOCATION (City, town, or county) (State)
---	---------------------	--	---

DATE REC'D BY LOCAL REG. JUN 3 1952	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue	ADDRESS
--	-------------------------------------	--	---------

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 _____

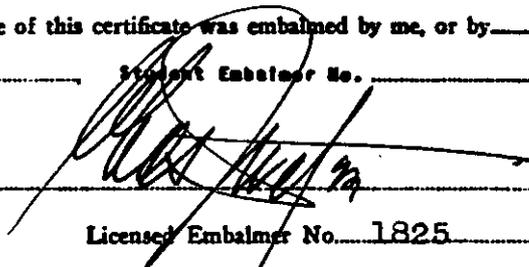
Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____



Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.