

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26801
6388

State File No.

FILED JUL 31 1953

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) _____
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital
e. STREET ADDRESS (If rural, give location) 25 1648 Carr 225/0

3. NAME OF DECEASED a. (First) Opal b. (Middle) B. c. (Last) Reed 4. DATE OF DEATH (Month) (Day) (Year) June 24 1953

5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Dec. -12, 1912 9. AGE (In years last birthday) 40 IF UNDER 1 YEAR Months 6 IF UNDER 24 HRS. Hours 12 Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Arkansas 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Rubin Reed 13b. MOTHER'S MAIDEN NAME Lillian Perkins 14. NAME OF HUSBAND OR WIFE Willaree Reed 1048 Carr St.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Cerfue Reed ADDRESS 1648 Carr St.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Empyema INTERVAL BETWEEN ONSET AND DEATH Undet.
ANTECEDENT CAUSES DUE TO (b) Undetermined
**This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.*
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 518X

22. I hereby certify that I attended the deceased from 6-10, 19 53, to 6-24, 19 53, that I last saw the deceased alive on 6-24, 1953, and that death occurred at 11:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw B Williams M. D. 23b. ADDRESS 2601 N Whittier St 23c. DATE SIGNED 6-25-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 6-30-53 24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. JUN 26 1953 REGISTRAR'S SIGNATURE Carl Smith 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 14 1954

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.....
Signature of Student Embalmer

Signed *Fulton E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address *Albany*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.