

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9763
Registrar's No.

FILED NOV 22 1954

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 4242 W. Cook 21190	
3. NAME OF DECEASED (Type or Print) a. (First) Willie b. (Middle) Reeder c. (Last) Reeder		4. DATE OF DEATH (Month) (Day) (Year) 10 25 54	
5. SEX Male 7		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH April 16, 1935	
9. AGE (In years last birthday) 19		10. IF UNDER 1 YEAR Months 6 Days 9	
11. IF UNDER 14 Hrs. Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) Marvell, Arkansas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	
10b. KIND OF BUSINESS OR INDUSTRY Pvt. Family		13a. FATHER'S NAME Ules Reeder	
13b. MOTHER'S MAIDEN NAME Hester Murff		14. NAME OF HUSBAND OR WIFE none	
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 Hester Reeder, 4242 W. Cook Avenue		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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myelogenous Leukemia ANTECEDENT CAUSES DUE TO (b) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 <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)	
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? 2041		22. I hereby certify that I attended the deceased from 10-17, 1954, to 10-25, 1954, that I last saw the deceased alive on 10-25, 1954, and that death occurred at 7:40 A.M., from the causes and on the date stated above.	
23a. SIGNATURE Edw. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 10-26-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 10/30/54		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates, 4107 Finney Ave.	
DATE REC'D BY LOCAL REG. OCT 27 1954		REGISTRAR'S SIGNATURE J. Carl Smith	

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.....
Licensed Embalmer No. 1825

P. O. Address 4107 Finney

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.