

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10938**  
**1995**

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 <b>Illinois</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, write RURAL and give OR township) <b>st. Louis</b>		c. CITY OR TOWN <b>Madison</b> <b>8/28</b>	
c. LENGTH OF STAY (In this place) <b>4 days</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>19 Peoples Hospital 0</b>			
e. STREET ADDRESS <b>32 807 franklin street</b>		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>SALLIE</b>	b. (Middle)	c. (Last) <b>REED</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb 25, 1957</b>
-------------------------------------	--------------------------	-------------	-----------------------	---

5. SEX <b>Female 3</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed 2</b>	8. DATE OF BIRTH <b>Feb 23, 1879</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
------------------------	-------------------------------	---	--------------------------------------	---	------------------------	-----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Gregory, Ark.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	---	---

13a. FATHER'S NAME <b>Clay Rusby</b>	13b. MOTHER'S MAIDEN NAME <b>Jane gdem</b>	14. NAME OF HUSBAND/OR WIFE
--------------------------------------	--	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Janie Pitts-807 franklin, Madison, Ill.</b>	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		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bilateral lobar pneumonia (Bilateral lobar pneumonia)</b>		
	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.		<b>490 X</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **2/21, 1957**, to **2/25, 1957**, that I last saw the deceased alive on **2/24, 1957**, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Alfred Williams MD</b>	23b. ADDRESS <b>501 Madison St Gregory, Ark</b>	23c. DATE SIGNED <b>2-27-57</b>
--	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>FEB 25 '57</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>East St. Louis, Illinois</b>
--	-----------------------------	------------------------------------	---

DATE REC'D BY LOCAL REG. <b>FEB 27 '57</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Funeral Home-East St. Louis, Ill.</b>	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.....  
Signature of Student Embalmer

Signed *Thomas Marshall Dabson*

Licensed Embalmer No. 4479  
2205 Missouri  
P. O. Address East St. Louis

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.