Health, Welfare Public Service

. 300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10939

FILED APR 15 1957 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3163

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL Length of stay in 1b: 04

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Texas
c. CITY OR TOWN: Naples 10700 Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Rural Route 31 Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle THOMAS Last REED

4. DATE OF DEATH: Month MARCH Day 30, Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 25, 1873
9. AGE (In years last birthday): 84 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): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Missouri. 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Reed
14. MOTHER'S MAIDEN NAME: Rhoda Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): Nil
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert Peterson, 1006 Dillon Court Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE (with metastases) — INTERVAL BETWEEN ONSET AND DEATH: 3MOS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 177X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from FEB. 20, 1957 to MARCH 29, 1957 and last saw her/him alive on MAR. 29, 1957
Death occurred at 8:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. L. Vermillion, M.D. (Degree or title) M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 3/30/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-30-57
23c. NAME OF CEMETERY OR CREMATORY: Licking Cemetery
23d. LOCATION (City, town, or county) (State): Licking, Missouri.

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.,
25. DATE RECD. BY LOCAL REG.: APR 1 '57
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.