

FILED MAY - 8 1957

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

15184

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3825

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, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 VA HOSPITAL		Length of stay in lb 22 YRS.	d. STREET ADDRESS 3729 OLIVE		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle REED Last			4. DATE OF DEATH Month APRIL Day 21 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/89	9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ERIE, PA.	
13. FATHER'S NAME CHARLES REED			14. MOTHER'S MAIDEN NAME LETICIA PHILLIPS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address VA HOSPITAL RECORDS, VAH, ST. LOUIS, MO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) DIABETES MELLITUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE - ANGINA					INTERVAL BETWEEN ONSET AND DEATH 4 HRS. 5 YRS. UNKNOWN
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 4/16/57 , to 4/21/57 and last saw ^{her} him alive on 4/21/57 Death occurred at 10:40 a. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Julien Baber MD</i>			22b. ADDRESS VAH, ST. LOUIS 6, MO.		22c. DATE SIGNED 4/21/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/23/57	23c. NAME OF CEMETERY OR CREMATORY National Cem		23d. LOCATION (City, town, or county) (State) Jeff. Bks Mo
24. FUNERAL DIRECTOR ADDRESS Edward Fendler 5611 South Grand Blvd			25. DATE RECD. BY LOCAL REG. APR 22 '57	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56
 All
 symptoms will be listed. All
 diseases in Part I must be
 causally related. Coroner
 cannot certify to a death
 due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in time

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 *Harry J. Schwan*
Licensed Embalmer No. *267*

P. O. Address *5611 S. 2nd*

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.