

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29930

STATE FILE NUMBER

FILED SEP 4 1957

318

1003

Registrar's No. 7886

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH a. COUNTY St. Louis Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN City		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hosp		d. STREET ADDRESS (If outside, give location) 2909 a Bailey	
3. NAME OF DECEASED (Type or print) First Middle Last Hannah Reed		4. DATE OF DEATH Month 8 Day 22 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 29 1891
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <i>Med</i>		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) St. Louis Mo.
13a. FATHER'S NAME Henry Reed		13b. MOTHER'S MAIDEN NAME Margaret Clooney	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) <i>No</i>		16. SOCIAL SECURITY NO. 490-36-9515	17. INFORMANT Address Mrs. Robert Guinner 2909 Bailey
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Colon</i>			INTERVAL BETWEEN ONSET AND DEATH
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) -			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 <i>July 6, 1956</i> to <i>August 22, 1957</i> and last saw her alive on <i>August 22, 1957</i> . Death occurred at <i>10:45 A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Thomas F. Summers, M.D.</i>		22b. ADDRESS <i>3854 Lindell, St. Louis 8</i>	22c. DATE SIGNED <i>8-23-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>8-24-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR <i>James F. Morrell</i> ADDRESS <i>3710 N. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 23 57</i>	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Robert M. Murray*

Licensed Embalmer No. *3749*
P. O. Address, *St. Louis, Mo.*

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.