

FILED NOV 22 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **42499**
11009
Registrar's No.

Registration District No. **318** Primary Registration District No. **1003**

V. S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 6626 Odell		STREET ADDRESS (If outside, give location) 6626 Odell	
3. NAME OF DECEASED (Type or print) First Russell Middle Reed Last Reed		4. DATE OF DEATH Month Nov. Day 15 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 Feb. 10, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Foreman - Terminal R.R. Co		10b. KIND OF BUSINESS OR INDUSTRY Retired 3 yrs	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown Reed		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Sadie Reed
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. No	
17. INFORMANT Sadie Reed		Address 6626 Odell St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia			INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease			5 yrs
DUE TO (c) Papillary Carcinoma aneurysm of Aorta			6 yrs
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 - SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 153-2	
20c. TIME OF INJURY Hour 9:40 P. Month, Day, Year		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 March 1957 to Nov. 15, 1957 and last saw him alive on Nov. 15, 1957 Death occurred at 9:40 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. R. Sheridan, M.D. (Degree or title)		22b. ADDRESS #16 Hampton Village Plaza	
22c. DATE SIGNED 11-16-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-18-57	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) Pacific, Mo
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. NOV 18 57	26. REGISTRAR'S SIGNATURE J. Carl Smith

All diseases in Part I must be causally related.

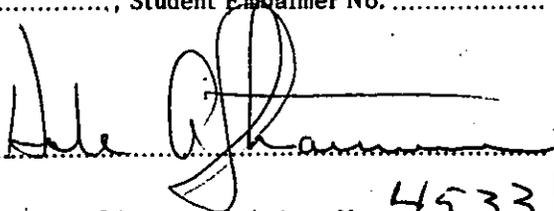
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. 4533

P. O. Address

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: I-I I I
If this body is not embalmed, fact should be so stated above.