Health, Welfare Public Service

300
1-57
8
64

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003418
STATE FILE NUMBER 2 955

FEB 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): DOA. City Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2269 2011 Mallinckrodt — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ROSE — Middle: — Last: REED

4. DATE OF DEATH: Month 1 Day 26 Year 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-13-1885
9. AGE (In years last birthday): 73 — 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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): St. Louis Mo 0
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: Andrew Killoran
13b. MOTHER'S MAIDEN NAME: Catherine Mullcahy
14. NAME OF HUSBAND OR WIFE: Otis 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.: —
17. INFORMANT: Otis Reed — Address: 2011 Mallinckrodt

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — Unknown
DUE TO (c) 331A
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Peptic Ulcer
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 1957 pm, to 1/26/58 and last saw her/him alive on Jan. 6, 1959
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] MD
22b. ADDRESS: 4161 Lindell Boulevard
22c. DATE SIGNED: 1/27/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-29-1959
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Mo

24. FUNERAL DIRECTOR: Chas Roth & Son — ADDRESS: 3516 & 14 Ele
25. DATE RECD. BY LOCAL REG.: JAN 27 '59
26. REGISTRAR'S SIGNATURE: [signature] MD
M.J.B.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be issued. 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 W E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, M

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.