

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023315

STATE FILE NUMBER

2 5415

FILED JUN 18 1959

Registration District No.

Primary Registration District No.

Registration No.

5-300
1-57

292
02

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5253 Schollmeyer			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Morton Reed				4. DATE OF DEATH Month Day Year June 5, 1959				
5. SEX Male <input type="checkbox"/>	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. 22, 1899		9. AGE (In years last birthday) 60	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) Ass't Mgr.			10b. KIND OF BUSINESS OR INDUSTRY Buxton & Skinner		11. BIRTHPLACE (City and state or country) Fort Worth Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wiley Reed			13b. MOTHER'S MAIDEN NAME Lottie Cotten			14. NAME OF HUSBAND OR WIFE Estelle 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. 489201-3329		17. INFORMANT Address Estelle Reed 5253 Schollmeyer			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis due</u> <u>Cerebral Arterio sclerosis</u> DUE TO (b) _____ DUE TO (c) <u>332x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cyelo nephritis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>16 day</u> <u>2-3 yrs</u>	
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. CITY, TOWN, OR LOCATION			20f. COUNTY STATE		
21. I attended the deceased from <u>3/22/50</u> to <u>6/5/59</u> and last saw him alive on <u>6/5/59</u> Death occurred at <u>9 AM (9:15 AM)</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Edwene W. Czuchinski MD</u>				22b. ADDRESS <u>3901 Cranford Sq</u>			22c. DATE SIGNED <u>6/5/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/8/59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery			23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u>		
24. FUNERAL DIRECTOR ADDRESS John L. Ziegenhein & Sons 7027 Gravois				25. DATE RECD. BY LOCAL REG. JUN 8 59		26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u> mrb		

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 *Donald Benz*

Licensed Embalmer No. *4863*

P. O. Address *Rt 4, Lumb. Md.*

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.