

Health, Public Service, 100, 157, Z, MEDICAL CERTIFICATION, USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE, Missouri State University retained.

XC-1522 143

SL 17294

FILED JUL 1 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023316

STATE FILE NUMBER 5674
Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **915 N. GRAND, ST. LOUIS, MO.** Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **VET. ADM. HOSPITAL** Length of stay in lb **1 hr. 20 min.**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **ILLINOIS** b. COUNTY **MADISON**
c. CITY OR TOWN **GRANITE CITY** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **2037 WASHINGTON** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
CHARLES C. REEDY

4. DATE OF DEATH Month Day Year
JUNE 14, 1959

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH **8/5/92** 9. AGE (In years, last birthday) **66** IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **PIPE FITTER**
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) **E. ST. LOUIS, ILL.**
12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **THOMAS REEDY** 13b. MOTHER'S MAIDEN NAME **MARY MONAHAN** 14. NAME OF HUSBAND OR WIFE **LILLY REEDY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give dates of service) **YES WW-1**
16. SOCIAL SECURITY NO. **333-03-2836** 17. INFORMANT Address **VA HOSP. RECORDS, 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) **GENERALIZED CARCINOMATOUS** INTERVAL BETWEEN ONSET AND DEATH **6 MONTHS**
Conditions, if any, due to (b) **TRANSITIONAL CELL CARCINOMA OF URINARY BLADDER** **12 MONTHS**
Other cause (c) **181.0**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
6/16/59

20a. ACCIDENT SUICIDE HOMICIDE NONE

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 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. **VA** attended the deceased from **6/14/59** to **6/14/59** and last saw **him** alive on **6/14/59**
Death occurred at **11:35 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Type or print) **A. H. BISCOP M.D.** 22b. ADDRESS **VAH, ST. LOUIS, MO.** 22c. DATE SIGNED **6/15/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE **6-17-59** 23c. NAME OF CEMETERY OR CREMATORY **Calvary** 23d. LOCATION (City, town, or county) (State) **Edwardsville Ills**

24. FUNERAL DIRECTOR **Preyer Funeral Home** ADDRESS **GRANITE CITY** 25. DATE RECD. BY LOCAL REG. **JUN 15 '59** 26. REGISTRAR'S SIGNATURE **mjs Earl Smith M.D.**

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Peper Funeral Home
Signed

Licensed Embalmer No.....

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.

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