

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027099

FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6695** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State</b>		d. STREET ADDRESS (If outside, give location) <b>1901 1/2 Biddle St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>May</b> Last <b>Reed</b>			4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-10</b>
9. AGE (last birthday) <b>49</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>3</b>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Cairo, Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Every Reed</b>	
13b. MOTHER'S MAIDEN NAME <b>Mabel Howard</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs Mildred Brown 920 Clarendon</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery embolism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 das.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Heart disease, rheumatic or congenital</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) <b>Uremia</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____			
20d. INJURY OCCURRED WHILE AT WORK <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 <b>2-9-31</b> to <b>7-15-59</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>7-15-59</b> Death occurred at <b>11:45</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. J. Heuser</b> (Degree or title) <b>MD</b>		22b. ADDRESS <b>5400 Arsenal Street</b>	22c. DATE SIGNED <b>7-15-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-20-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ellis Funeral Home 2820 Stoddard Street</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 17 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William E. Culke

Licensed Embalmer No. 419

P. O. Address St. Louis

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.