

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031120

FILED VS AUG 26 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2225

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo.</u>		Length of stay in 1b <u>43 days</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robt. Koch Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2841 Abner Place</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u></u> Last <u>Reed</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>59</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>N</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-99</u>		9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Wentzville Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>William Jones</u>				13b. MOTHER'S MAIDEN NAME <u>Alice Rack</u>				14. NAME OF HUSBAND OR WIFE <u>Ferdinand Reed</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Robt. Koch Hosp. Record Room, Koch Mo.</u>							
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>Metastatic Carcinoma</u>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (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)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>											
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 <u>7-1-59</u> to <u>8-14-59</u> and last saw her/him alive on <u>8-14-59</u> Death occurred at <u>9:35 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Bernard Freedman M.D.</u>				22b. ADDRESS <u>Robt. Koch. Hosp. Koch, Mo.</u>				22c. DATE SIGNED <u>8-11-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/19/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Charles J. Gates, 4107 Finney</u>				25. DATE RECD. BY LOCAL REG. <u>8-18-59</u>		26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>							

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 _____

Licensed Embalmer No. 4580

P. O. Address 4107 Fern

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.