

FILED VS NOV 16 1959

59-042397

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9636** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Pine Lawn</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7120 Beulah Pl.</b>	

3. NAME OF DECEASED (Type or print) <b>CALLIE REID</b>			4. DATE OF DEATH Month <b>October</b> Day <b>20th</b> Year <b>1959</b>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/10/75</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Carroll, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Doyle Reid</b>	13b. MOTHER'S MAIDEN NAME <b>not known</b>	14. NAME OF HUSBAND OR WIFE <b>Everett Reid</b>
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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 <b>Harold Reid, 7120 Beulah Pl.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		<b>1 1/2 years</b>
DUE TO (b) <b>Fractured Hip, operated</b>		<b>22 days ago</b>
DUE TO (c) <b>903.0 20</b>		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.)
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20c. TIME OF INJURY Hour <b>9:25 a.m.</b> Month <b>9</b> Day <b>25</b> Year <b>59</b>	<b>Fell in own yard &amp; fractured left hip.</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>3P Home</b>	20f. CITY, TOWN, OR LOCATION <b>Pine Lawn Mo.</b>	COUNTY _____ STATE _____
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21. I attended the deceased from **Sept 25-59** to **Oct 20-59** and last saw her <sup>him</sup> alive on **Oct 20-59**  
Death occurred at **1:40 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John P. Morris M.D.</b>	22b. ADDRESS <b>8209 E. Broadway</b>	22c. DATE SIGNED <b>10/20/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>10/24/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Corning Cemetery</b>	23d. LOCATION (City, town, or county) <b>Corning, Ark.</b>
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24. FUNERAL DIRECTOR <b>Emil J. Heitzenroeder, 8319 Hallsferry</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 21 1959</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*O.K. Smith*  
*Paul J. Smith*  
*Sept 15/59*

non-attendance of any, which may give rise to above cause (a), making the underlying cause last.

*m. J. B.*

State of Missouri

Missouri

Missouri

**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 J. W. Bankley  
Licensed Embalmer No. 365  
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.