URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-040137

FILED VS NOV 3 1960

ENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10410

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 6 Wks.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2010 McCausland
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Eleanor Middle: NMI Last: Reed

4. DATE OF DEATH: Month Oct. Day 27th Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1-4-1903

9. AGE (last birthday): 57

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Samuel Bannon

13b. MOTHER'S MAIDEN NAME: Catherine Scannell

14. NAME OF HUSBAND OR WIFE: Thomas Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 489-14-1719

17. INFORMANT: Thomas Reed Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic Heart Disease — yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 420.0

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

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. I attended the deceased from 1946, to 10-21-60 and last saw her/him alive on 10-26-60
Death occurred at 1 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] M.D. (Degree or title)

22b. ADDRESS: 634 N. Grand

22c. DATE SIGNED: 10-31-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 10-29-1960

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: JAY B. SMITH, Maplewood, Mo.

25. DATE RECD. BY LOCAL REG.: OCT 27 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

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 H. C. Burgess

Licensed Embalmer No. 4029

P. O. Address Naplw.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.