IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 26 1960 318 1003 10185 -60-040143

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 3 wks.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 8 Windemer Pl. — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5531 Clemens Ave. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MAUDE Middle HELEN Last REIS
4. DATE OF DEATH: Month Oct. Day 18, Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Oct. 11, 1888
9. AGE (last birthday): 72 — IF UNDER 1 YEAR: Months, Days 6 — 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:
11. BIRTHPLACE (City and state or country): Waco, Texas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Charles Campbell
13b. MOTHER'S MAIDEN NAME: Nancy Edwards
14. NAME OF HUSBAND OR WIFE: Andrew Reis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Andrew Reis 5531 Clemens Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis: Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9-20-1960
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) General arteriosclerosis — years.
DUE TO (c) 332xH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Carcinoma of breast 10/21/1958.

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 1938, to 10-18 60 and last saw her alive on 10-17-60
Death occurred at 10-18-1960 10:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Joseph W. Stewart (Degree or title) MD
22b. ADDRESS: 4660 Maryland St Louis Mo
22c. DATE SIGNED: 10-20-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 21, 1960
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: A.H. Bocklage — ADDRESS: 6536 Clayton Rd.
25. DATE RECD. BY LOCAL REG.: OCT 20 1960
26. REGISTRAR'S SIGNATURE: Hoard 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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Robert M. Murray

Signature of Student Embalmer

Licensed Embalmer No. 3749

P. O. Address St Louis M

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.