

FILED VS. NOV 23 1960 318

1003

11078

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Glasgow Village 37	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist		d. STREET ADDRESS (If outside, give location) 10658 Dunkeld Circle	

3. NAME OF DECEASED (Type or print) First Middle Last Mathew Vernon Reed			4. DATE OF DEATH Month Day Year November 7, 1960		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-6-60	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 8	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY 570003 Missouri	11. PLACE OF BIRTH (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Vernon Raymond Reed	13b. MOTHER'S MAIDEN NAME Louise Dehas	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	Address
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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: IMMEDIATE CAUSE (a) <i>anoxia</i> <i>premature Separation of placenta</i> DUE TO (b) <i>previous Cesarean</i> DUE TO (c) <i>761.5</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>
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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	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. 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
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21. I attended the deceased from <u>11-6-60</u> to <u>11-7-60</u> and last saw her/him alive on <u>11-6-60</u> Death occurred at <u>12:15A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
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22. SIGNATURE (Degree or title) <i>George Anetym, D.</i>		22b. ADDRESS <i>4668 Manchester</i>	22c. DATE SIGNED <i>11-8-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-30-60</i>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
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24. FUNERAL DIRECTOR <i>Rowland Mortuary Svc. 410406 Manchester</i>	25. DATE RECD. BY LOCAL REG. <i>NOV 17 1960</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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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. _____

P. O. Address _____

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.