

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

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, MISSOURI		c. CITY OR TOWN Qulin	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Box No. 83	
3. NAME OF DECEASED (Type or print) First FRANK Middle M. Last REID		4. DATE OF DEATH Month JANUARY Day 21 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Misc Public Work		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) Alabama
13a. FATHER'S NAME Grover Reid		13b. MOTHER'S MAIDEN NAME Rosa Lee Purser	14. NAME OF HUSBAND OR WIFE Helon Reid
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Helon Reid, Qulin, Missouri.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS WITH METASTASES			INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 150x			
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"/> N. <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ 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 _____
21. I attended the deceased from AUG. 28, 1958 to JAN. 21, 1961 and last saw her alive on JAN. 21, 1961 Death occurred at 3:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. O. Vermillion (Degree or title) <i>C. O. Vermillion, M.D.</i>		22b. ADDRESS M. D. BARNES HOSPITAL	22c. DATE SIGNED 1/21/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/21/61	23c. NAME OF CEMETERY OR CREMATORY Qulin Cemetery	23d. LOCATION (City, town, or county) (State) Qulin, Missouri.
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd		25. DATE RECD. BY LOCAL REG. JAN 24 1961	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

FEB 1 1961

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

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.