

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY													
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 12 DAYS		c. CITY OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>											
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4408 ST. LOUIS AVE.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last LITFIELD REED				4. DATE OF DEATH Month Day Year 4/25/61													
5. SEX MALE		6. COLOR OR RACE NEGRO		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12/17/18		9. AGE (last birthday) 42		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD WORKER				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) WEST POINT, MISS.		12. CITIZEN OF WHAT COUNTRY U.S.A.									
13a. FATHER'S NAME WILLIAM REED				13b. MOTHER'S MAIDEN NAME MARY YATES				14. NAME OF HUSBAND OR WIFE -----									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II				16. SOCIAL SECURITY NO.				17. INFORMANT Samuel Reed 4359 St. Ferdinand Ave.									
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) ASPIRATION										5 MIN							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)										DUE TO (b) ACUTE PERITONITIS				3 DAYS			
										DUE TO (c) SMALL BOWEL PERFORATION				3 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ACUTE CHRONIC ALCOHOLISM										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							
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							
NA attended the deceased from 4/13/61, to 4/25/61 and last saw him alive on 4/25/61				Death occurred at 6:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE DAVID P. O'SULLIVAN (Degree or title) M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.				22c. DATE SIGNED 4/26/61									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-28-61		23c. NAME OF CEMETERY OR CREMATORY West Point, Mississippi		23d. LOCATION (City, town, or county) West Point, Mississippi		(State)									
24. FUNERAL DIRECTOR G. Wade Granberry 4202 Finney Ave.				25. DATE RECD. BY LOCAL REG. APR 27 1961		26. REGISTRAR'S SIGNATURE Earl 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Edward A Flynn

Licensed Embalmer No. 21424

P. O. Address 4202 Main

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.