

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032821

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

6674

FILED AUG 20 1962

VS 300 Rev. 4/59	DATE AMENDED
1	
3	
4 <i>2</i>	
5 <i>1</i>	
6	
7 <i>1</i>	
8 <i>1</i>	
9	
10	
11	
12 <i>2-3</i>	
13	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN East St. Louis, Illinois	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (if outside, give location) 810 South 17th Street	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES MILTON REED		4. DATE OF DEATH Month Day Year JULY 3, 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/8/1909
9. AGE (last birthday) 52		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) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania R.R.	11. BIRTHPLACE (City and state or country) Altheimer, Arkansas
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME LANE FRANK REED	
13b. MOTHER'S MAIDEN NAME EVA LEWIS		14. NAME OF HUSBAND OR WIFE BESSIE REED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Bessie Reed, 810 South 17th Street,		Address E. St. Louis, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cranial hemorrhage; Contrib: Multiple comminuted fractures of skull; Bilateral lobar pneumonia; suffered when deceased jumped from window to ground below at St. Mary's Infirmary while SUFFERING FROM MENTAL ABERRATION ON			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) July 3, 1962. SUICIDE			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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) (see above) 978 X	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 7-3-62		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) hospital		20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 4:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Nelson L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 7-6-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/8/62	23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memory	
23d. LOCATION (City, town, or county) Stokey Township, Illinois		23e. STATE Illinois	
24. FUNERAL DIRECTOR Marion St. Clair		25. DATE RECD. BY LOCAL REG. JUL 6 1962	
ADDRESS 2114 Missouri Avenue E. St. Louis, Illinois		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 Marion E. Offner

Licensed Embalmer No. 5177

P. O. Address East St. Louis, Ill.

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.