

REC'D MAY 16 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15096

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 3 Registration District No. 400
(b) Township Prairie Primary Registration District No. 5553B Registered No. 90
(c) City Little Blue Mo 1 (d) Street No. Jackson Co Home St.
(e) Length of residence in city or town where death occurred yr. mos. 12 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 823 Independence St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write how) Don't know
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown 1876
7. AGE YEARS 63 MONTHS Unknown DAYS Unknown If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, boatman, etc. Common Laborer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know13. NAME Don't know14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know15. MAIDEN NAME Don't know16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know17. INFORMANT (ADDRESS) County Home Records Little Blue Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Western Dental College DATE 4-15-3919. FUNERAL DIRECTOR (ADDRESS) Flynn + Greenstreet R. C. Mo.20. FILED 4/17/1939 Lane S. Barnes Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-15-39 1939

I HEREBY CERTIFY, That I attended deceased from April 8 - 1939 to April 15 - 1939
I last saw him alive on April 14 - 1939 Death is said to have occurred on the date stated above, at 3:30 a.m.
The principal cause of death and related causes of importance were as follows:

Arterio Sclerotic Insufficiency

Other contributory causes of importance: 92 WName of operation Thyroidectomy Date of 20What test confirmed diagnosis? Thyroidectomy Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 4-15-39Where did injury occur? at home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.Manner of injury at homeNature of injury at home24. Was disease or injury in any way related to occupation of deceased? If so, specify at home(Signed) L. W. Boskey M. D.(Address) 2028 Union St.

duration of work
71
1875

4 12 01

Walt Reed
1875

Walt Reed

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed *Edw. J. Evans*

Licensed Embalmer No. *3876*

P. O. Address *1819 E. 15th St. N.W.*

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 this body is not embalmed, above space should be left blank.