

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D JUL 14 1939 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22053
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 296
 (b) Township Union Primary Registration District No. 4180
 (c) City Union (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Ellen Agnes Reed
 (a) Residence, No. Union, Missouri 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Thomas Reed

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 7, 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
85 10 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired House-keeper
 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) St. Louis 0
 (STATE OR COUNTRY) Missouri

FATHER 13. NAME John Thomas Nixon 4
 14. BIRTHPLACE (CITY OR TOWN) England 9
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Hannah E. Craven
 16. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

17. INFORMANT Maggie McCrady
 (ADDRESS) St. Louis, Missouri

18. BURIAL, CREMATION, OR REMOVAL Union Cemetery
 PLACE Union, Mo. DATE June 20, 1939

19. FUNERAL DIRECTOR (NAME) Union Funeral Home
 (ADDRESS) Union, Mo. (Wm. H. Horn, Mgr.)

20. FILED 6-19-39 Reid T. Houser 854
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6/16, 1939, to 6/17, 1939
 I last saw her alive on 6/17, 1939. Death is said to have occurred on the date stated above, at 8 p.m.
 The principal cause of death and related causes of importance were as follows:

Autismochrosis
Cardiac decompensation
(Complete)
Old age
 Date of onset _____

Other contributory causes of importance: 95%
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Michael J. Hyppich, M. D.
 (Address) Union, Mo.

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.....

Licensed Embalmer No. 3175

P. O. Address Union, 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 this body is not embalmed, above space should be left blank.