

DEC 12 1939

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

40355
Do not use this space.

1. PLACE OF DEATH

(a) County Wentworth Registration District No. 25
(b) Township Wendover Primary Registration District No. 6262 Registered No. 1394
(c) City Wendover (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. ds. (1) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

300 Bessie Lee Reed
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Deceased
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 18
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. unpaid
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) mo o

FATHER 13. NAME Geo Reed o
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____ o

MOTHER 15. MAIDEN NAME Freddie Mangold
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) Dr. H. H. ...

18. BURIAL, CREMATION, OR REMOVAL PLACE Wendover DATE Oct 10

19. FUNERAL DIRECTOR (ADDRESS) ...

20. FILED Nov 8 1939 M. V. Mumma Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 8 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 15 1939 to Oct 8 1939
I last saw deceased alive on Oct 2 1939 Death is said

to have occurred on the date stated above, at 9 am.
The principal cause of death and related causes of importance were as follows:

undiluted Xerom
oral if used
Class Date of onset _____

Other contributory causes of importance: 157C

Name of operation none Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 1939
Where did injury occur? none (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) B. B. ..., M. D.
Address ...

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

RECEIVED

District Health Officer No. 2,

District File Number

9-261

Date Filed

11/7

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 53
(b) Township Anderson Primary Registration District No. 6262 Registered No. 1394
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 21, 1939

I last saw h..... alive on....., 19..... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 18

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

13. NAME

Name of operation..... Date of.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Accident, suicide, or homicide?..... Date of injury....., 19.....

17. INFORMANT (ADDRESS)

Where did injury occur?..... (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE..... DATE....., 19.....

Manner of injury.....

Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....

20. FILED Nov 8, 1939 M. V. Mumma Local Registrar

If so, specify

(Signed) B. E. Ellis, M. D.

(Address) Gideon

