

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

43935

Registration District No. 515Primary Registration District No. 5684Registrar's No. 10

## 1. PLACE OF DEATH:

- (a) County Livingston
- (b) City or town Rural-Blue Mound Tws.  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: ✓  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)
- In this community 3 days  
years, months or days

## 3. (a) PRINT FULL NAME

Fredrick Melvin Reid 3rd8. (b) If veteran,  
name war \_\_\_\_\_8. (c) Social Security  
No. \_\_\_\_\_4. Sex Male 5. Color or  
race White6. (a) Single, widowed, married,  
divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased December 12 1939  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
0 0 3 hr. min.9. Birthplace Livingston Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER { 12. Name Melvin F. Reid

18. Birthplace Livingston Co. Missouri  
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Mary Lou Hiskett

15. Birthplace Livingston Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. F. Reid
- (b) Address R. F. D. Dawn, Missouri
17. (a) Burial (b) Date thereof 12-16-'39  
(Burial, cremation, or removal) (Month) (Day) (Year)
- (c) Place: burial or cremation Mt. Olive
18. (a) Signature of funeral director F. B. Norman
- (b) Address Chillicothe, Missouri
19. (a) Dec-15-1939 (b) Wm. A. Hayes  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Livingston
- (c) City or town Rural  
(If outside city or town limits, write "RURAL")
- (d) Street No. 2 1/2 miles east of Dawn, Mo.  
(If rural, give location)
- (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15th  
year 1939 hour 10 minutes 30 A.M.21. I hereby certify that I attended the deceased from Dec 14, 1939, to Dec 15, 1939;that I last saw him alive on Dec 15, 1939,  
and that death occurred on the date and hour stated above.Immediate cause of death Lobar Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_
- (b) Date of occurrence \_\_\_\_\_
- (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

23. Signature W. C. Elliott (M. D. or other) MD  
Address Chillicothe Mo Date signed 12-15-39

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.

RECEIVED

District Health Officer No. 11,

District File Number 140-1858

Date Filed JAN 10 1948

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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.....

P. O. Address.....

**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.