

FILED MAR 7 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
316 East Cypress
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No.
(Specify whether
In this community 40 years.
years, months or days)

3. (a) PRINT FULL NAME Charles White Reid

3. (b) If veteran, name war No. 8. (c) Social Security No. No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Warlaw Reid. 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased: April 7 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 10 4 hr. min.

9. Birthplace Jefferson County Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist.
Dentistry.

11. Industry or business Dentistry.

12. Name William Reid
13. Birthplace Ken tucky
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Russell
15. Birthplace Mississippi Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Grojean
(b) Address 1328 W. Sunset, Decatur, Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/1940
(Month) (Day) (Year)
(c) Place: burial or cremation I.O.O.F. Cemetery

18. (a) Signature of funeral director John P. Hummel

(b) Address Charleston, Mo.

19. (a) 2-15-40 (Date received local registrar) (b) J. S. Vernon (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Charleston
(If outside city or town limits, write "RURAL")
(d) Street No. 316 East Cypress
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 11th
year 1940 hour 2 minute 25 a. m.

21. I hereby certify that I attended the deceased from Jan. 23
1940, to Feb. 11, 1940;

that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure
Decompensating

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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)
(e) Means of injury _____

23. Signature Paul S. Bauer (M. D. or other) _____

Address Charleston Date signed 2/13/40

Duration

1 WK

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No.

District File Number 340-6

Date Filed 3/5/40

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

John P. Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, N.C.

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.