

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11656

APR 23 1940
Registration District No. 538

Primary Registration District No. 5729

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Rural Polk Twp
(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 7
(Specify whether
In this community _____
years, months or days) ✓

3. (a) PRINT FULL NAME Edgar Reed 387
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex W 5. Color or race W 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife not known (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 10 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Madison Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____

MOTHER FATHER
12. Name John Reed
13. Birthplace Madison Co. Mo
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth
15. Birthplace Madison Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ed Allen
(b) Address Bellevue mine Mo

17. (a) Burial (b) Date thereof Aug 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Black Mountain

18. (a) Signature of funeral director Ed H. H. H.
(b) Address Fredericktown Mo

19. (a) Incl 20-1040 (b) J. C. S. Laughlin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19
year 11 hour _____ minute 15 M.

21. I hereby certify that I attended the deceased from 3/12
_____ 19____, to _____ 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Labor Duration _____

Due to Injury _____

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?
461 _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. Harry Barton (M. D. certifier)
Address Fredericktown Mo Date signed 3/22/40

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

Rev. 5-17-39
Form 1 X19311

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.

OCT 14 1946

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 11656
Registrar's No. 18

Registration District No. 539

Primary Registration District No. 5729

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

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Roll, T.P.
(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 _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME LE Roy Reed

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 14-1941 (b) S. C. S. Conagher (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month mch day 19 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
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) _____ Means of injury _____

23. Signature W. Harry Barron (M. D. or other) _____
Address Fredericktown Mo Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

11656 (1940)