

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12540

State File No.

Registrar's No.

APR 25 1940

Registration District No.

Primary Registration District No.

4479

18

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Slater
(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 years (Specify whether

In this community 301 years, months or days)

3. (a) PRINT FULL NAME Anna Thomas Reed

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

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

6. (b) Name of husband or wife Harry Reed 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased January-6-1863 (Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 10 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name John Swinney

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

14. Maiden name Margaret + Patrick

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

16. (a) Informant Harry Reed

(b) Address Slater Mo

17. (a) Removal (b) Date thereof 3-18-40 (Month) (Day) (Year)

(c) Place: burial or cremation Arrow Rock Mo

18. (a) Signature of funeral director James + Sage

(b) Address Slater Mo

19. (a) 3-16 (b) W. M. Little (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Slater (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 March day 16 year 1940 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept. 1936 to March 1940 that I last saw her alive on March 16 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3/13/40

Due to Hypertension ?

Due to Ch. Myocarditis ?

Ch. Endocarditis ?

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

Major findings: Of operations not done 9.2.4

Of autopsy not done

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?

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

23. Signature W. M. Little (M. D. or other)

Address Slater, Mo Date signed 3/18/40

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

RECEIVED
District Health Officer No. 8,
Practice File Number
Date Filed 4-16-40

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

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.