

MAY 13 1940

Registration District No. 347

Primary Registration District No. 3018

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

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

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

In this community 78 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")

(d) Street No. 349 North Water St
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME BEVERLY REED 3rd

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

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

6. (b) Name of husband or wife Cora Belle Reed 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased December 25 1960
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation General Work

11. Industry or business _____

12. Name La Fayette Reed

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

14. Maiden name Mary

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

16. (a) Informant's own signature Sra Reed

(b) Address _____

17. (a) Burial (b) Date thereof May 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton, Mo.

18. (a) Signature of funeral director Spaw Hon

(b) Address Clinton, Mo.

19. (a) 5-4-40 (b) A. J. R. Haneyton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1940 hour 3:30 minute A. M.

21. I hereby certify that I attended the deceased from March 27, 1940 to April 27, 1940
that I last saw him alive on April 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart with possible embolism
Due to Embolism

Other conditions Acute myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) NO
(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? _____

23. Signature Dr. P. S. Halligsworth
Address Clinton, Mo. Date signed 5/1/40

Duration

immediate

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39 I 110811

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.

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

Loren H. Anderson

Licensed Embalmer No. *3641*

P. O. Address *Clinton, Mo.*

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

State File No. 14992

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Hopewell
(b) City or town Clinton
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Beverly Reed

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

4. Sex m 5. Color or race e 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Dec 25 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>4</u>	<u>3</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-4-40 (b) W. J. B. Humphreys
(Date received local registrar) (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.

20. DATE OF DEATH: Month apr day 28
year 1940 hour 3 minute 30 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) _____ (e) Means of injury _____

23. Signature P. S. Hallingworth (M. D. or other)

Address Clinton _____ signed _____

SUPPLEMENTAL

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

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

S-14992