FILED JUN 10 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

18023
Do not use this space.

1. PLACE OF DEATH
(a) County Callaway 3 Registration District No. 104
(b) Township or City Fulton Primary Registration District No. 3008 Registered No. 142
(c) (d) Street No. State Hospital #7 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Luke Reed
(a) Residence, No. Mexico, MO-0 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 27, 1879
7. AGE YEARS 60 MONTHS 4 DAYS 24 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) DK
11. Total time (years) spent in this occupation DK

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI 0

FATHER
13. NAME J. Reed
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI 0

MOTHER
15. MAIDEN NAME Susie Stults.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI 0

17. INFORMANT (ADDRESS) Hosp. Records

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mexico MO DATE 5-23 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. L. Reynolds Jr. Mexico, MO

20. FILED 5-23, 1940 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 21, 1940, to May 22, 1940
I last saw him alive on May 22, 1940 Death is said to have occurred on the date stated above, at 4:45 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebro-spinal meningitis	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Spinal fluid Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? No (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Forrest Thomas, M. D.
(Address) State Hospital No 1 Fulton Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

50M-9-19-38 I X16605

7460

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.

S. No. 2B
—2-21-40
1 X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18023

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 142

SUPPLEMENTARY

1. PLACE OF DEATH
(a) County Callaway
(b) City or town Fulton
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Luke Reed
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Col
6. (a) Single, widowed, married, divorced S
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 60 Months 74 Days 24 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebro Spinal Meningitis	
Due to Nonepidemic Cerebrospinal Meningitis —	
Due to	
Other conditions (Include pregnancy within 3 months of death) 7 9 W	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Forrest Thomas (M. D. or other)
Address Fulton Mo. Date signed

S-18023