

No. 2
13-40
X23139

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3135
Registrar's No.

Registration District No. 449 Primary Registration District No. 618

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

1. PLACE OF DEATH: Laclede Stage
(a) County Laclede
(b) City or town St. Louis
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)

3. (a) PRINT FULL NAME Larcena Elizabeth Reid
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Samuel N Reid 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name Emeline Lillard

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

16. (a) Informant Samuel N Reid

(b) Address Brownfield Mo

17. (a) Burial (b) Date thereof Jan 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads

18. (a) Signature of funeral director None
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 5300
(a) State Mo (b) County Laclede
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1941 hour 11 minute a M.

21. I hereby certify that I attended the deceased from Jan 23 1941 to Jan 24 1941
that I last saw hER alive on Jan 23 1941
and that death occurred on the date and hour stated above.

Immediate cause of death acute
Uremic Poisoning

Due to nephritis
Due to _____

Other conditions acute Mitral Stenosis
(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? Y

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Roland E. Gaston (M. D. or other) D. O.
Address St. Louis Mo Date signed 1-27-41

132

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3135-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 449

Primary Registration District No. 5618

Registrar's No.

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

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Larrena Elizabeth Reid

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

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

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 66 Months 7 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-7-41 (b) J. M. Lamb
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 24 year 1941 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) (e) Means of injury _____

23. Signature Boland & Garter (M. D. or other) _____

Address Raley Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 313J

Registration District No. 449

Primary Registration District No. 5618

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Osage
(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)

3. (a) PRINT FULL NAME

Larrena Elizabeth Reed

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years 66

Months 7

Days 11

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) _____

(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)

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 Jan day 24
year 1941 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.

Immediate cause of death acute uremia

poisoning

Due to hepatic chronic

Due to Bad teeth + tonsils

Other conditions mitral stenosis

(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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER