No. 2
-4-41
17-39
X26390

WITH AUG 8 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24621

Registration District No. 89 Primary Registration District No. 3007 Registrar's No. 285

1. PLACE OF DEATH:
(a) County: Butler County
(b) City or town: Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Brandon Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 13 days. In this community: 15 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Ripley 091
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No): 1
If yes, name country

3. (a) PRINT FULL NAME: DON V. REID
3. (b) If veteran, name war:
3. (c) Social Security No. 498-09-9367

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mable Sarum
6. (c) Age of husband or wife if alive: 26 years
7. Birth date of deceased: May - 12 - 1909 (Month) (Day) (Year)

8. AGE: Years 32 Months 2 Days 6 If less than one day hr. min.

9. Birthplace: Pocahontas (City, town, or county) Ark. (State or foreign country)
10. Usual occupation: Farming for self
11. Industry or business:
FATHER
12. Name: William Reid
13. Birthplace: — (City, town, or county) Ind. (State or foreign country)
MOTHER
14. Maiden name: Lula Lanham
15. Birthplace: Salem (City, town, or county) Ark. (State or foreign country)
16. (a) Informant: Mrs. Mable Reid (wife)
(b) Address: Doniphan Mo. R-6
17. (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof: 7-26-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Lone Star Cemetery
18. (a) Signature of funeral director: H. Jordan, Doniphan Mo.
(b) Address: Doniphan Mo.
19. (a) 7/22/41 (Date received by local registrar) (b) Kate Lutz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1941 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from July - 6 - 1941 to July - 19 1941 that I last saw him alive on July - 1, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: a. Peritonitis	7-6-41
Due to: Gangrenous appendicitis	7-4-41
Due to:	
Other conditions (Include pregnancy within 3 months of death): 1	

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: W. R. Simpson (M. D. or other) M
Address: Poplar Bluff, Mo. Date signed: 7-25-41

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 2
District File Number 8-41-10
Date Filed 8-6-41

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
—8-21-41
I X29288

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. 24 621

Registration District No. 89 Primary Registration District No. 3607 Registrar's No. 285

1. PLACE OF DEATH
(a) County Butler County
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Brandon Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 da (Specify whether years, months or days)
In this community LE

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ripley
(c) City or town (15 MRS) RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. Gatewood, Mo
(If rural, give location) Gatewood Twp
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Donald Reid
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
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 32 Months 2 Days 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) (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) 9-22-41 (Date received local registrar) (b) Bellekinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 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.

	Duration
Immediate cause of death	
Due to	
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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY