No. 2
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7-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 1 1941

Registration District No. 8 2 4

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26355

Primary Registration District No. 6073

Registrar's No.

1. PLACE OF DEATH:

(a) County: Shannon

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Delaware P.O. Delaware Twp.

(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: Mo (b) County: Shannon 01

(c) City or town: Rural - Delaware Twp. 0

(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.? 0 years.

3. (a) PRINT FULL NAME: William Russell Reed

3. (b) If veteran, name war: X

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Ann Rose

6. (c) Age of husband or wife if alive: 38 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years: 56 Months: Days: If less than one day: hr. min.

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

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: unknown

13. Birthplace (City, town, or county): unknown (State or foreign country): 9

MOTHER 14. Maiden name: Evaline Scott

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

16. (a) Informant: E. E. Reed

(b) Address: Eunice Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year): June - 14 - 1941

(c) Place: burial or cremation: Delaware Cemetery

18. (a) Signature of funeral director: None

(b) Address:

19. (a) 6 - 14 - 41 (Date received local registrar) (b) Grant Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12 year 1941 hour 9 minute 30 P 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: Carcinoma of Stomach

Duration

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)

(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: Grant Hyde (M. D. or other) D

Address: Eunice Date signed 6-14-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 741813
Date Filed

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.