30141

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 9 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 74

Primary Registration District No. 5295

Registrar's No. 30-40

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

1. PLACE OF DEATH:

(a) County Clinton

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

(c) Name of hospital or institution: Plattsburg RR #1
(If not in hospital or institution, write street number or location)

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

In this community 3 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton

(c) City or town R.R. #1
(If outside city or town limits, write "RURAL")

(d) Street No. non
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME CORNELIA ANN. Reed

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife W. Price Reed

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

7. Birth date of deceased April (Month) 19 (Day) 1857 (Year)

8. AGE: Years 85 Months 5 Days 2 If less than one day ..... hr. ..... min.

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

10. Usual occupation House Wife

11. Industry or business " "

FATHER
12. Name not known
13. Birthplace " " 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name not known
15. Birthplace " " 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nova Reed

(b) Address Plattsburg R.R. #1

17. (a) ..... (Burial, cremation, [illegible]) (b) Date thereof 9 (Month) 23 (Day) 42 (Year)

(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Jas L Martin

(b) Address Plattsburg

19. (a) Sept 20-42 (Date received local registrar) (b) Wm A C Harrell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21 year 1942 hour 3:15 minute P M.

21. I hereby certify that I attended the deceased from Sept 19, 19..., to Sept - 4, 1942 that I last saw her alive on Sept 19, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to

Due to

Other conditions 97
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration: non known

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 P M Steckman (M. D. or other)

Address Plattsburg Mo Date signed 9-23-42

(Licensed Embalmer's Statement on Reverse Side)

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 Jas. L. Martin

Licensed Embalmer No. 4303

P. O. Address Plattsburg

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to the above constitutes grounds for revocation of license.)

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

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Registration District No. 74 Primary Registration District No. 5295 Registrar's No. 30-40

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

1. PLACE OF DEATH:

(a) County: Clinton

(b) City or town: Rural
(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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Cornelia Ann 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: widowed

6. (b) Name of husband or wife: W. Price Reed

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

7. Birth date of deceased: April (Month) 19 (Day) 1853 (Year)

8. AGE: Years 85 Months 5 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 21 year 1943 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 — 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY