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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2282

State File No. .....

FILED JAN 30 1943

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 6

1. PLACE OF DEATH

(a) County Greene

(b) City or town Springfield ~~Twp.~~
(If outside city or town limits, write "RURAL," and name of township)

(c) Name of hospital or institution: 514 East Elm St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 11 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town Springfield ~~Twp.~~
(If outside city or town limits, write "RURAL")

(d) Street No. 514 East Elm St.
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Herschel V. Reid

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race W.

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

6. (b) Name of ~~husband~~ or wife Ella Reid

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased July 19 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 14 If less than one day ..... hr. ..... min.

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

10. Usual occupation Merchant

11. Industry or business .....

FATHER
12. Name G. G. Reid
13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ella Reid

(b) Address 514 East Elm St.

17. (a) Burial Springfield (b) Date thereof Jan. 5 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bullman Mo.

18. (a) Signature of funeral director T. B. Shaffer

(b) Address Ozark Mo.

19. (a) 1-5-43 (b) Harry M. Hindley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13 year 1943 hour 5 minute 5:00 P. M.

21. I hereby certify that I attended the deceased from Nov 23 1942 to Jan 3 1943 that I last saw him alive on Jan 2 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Cause	
Due to Hypertension Cardiovascular disease	Not Known
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy	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 C. B. Collins (M. D. ~~or other~~)

Address 318½ College St. Springfield Mo. Date signed 1-4-43

(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.....

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.

No. 2B
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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. 2282

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 6

1. PLACE OF DEATH:
(a) County: Green
(b) City or town: Springfield
(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: Hershel W. Reed
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
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 years
7. Birth date of deceased: July (Month) 19 (Day) 1870 (Year)
8. AGE: Years 75 Months 5 Days 10 If less than one day min.
9. Birthplace (City, town, or county) Mo. (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 July Day 19 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 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: Uremia coma	
Due to: Hypertension Cardiac Vascular disease. Renal	
Due to: disease. Myocardiopathy No Paralysis of any kind	
Other conditions (Include pregnancy within 3 months of death): Has Cancer die either Prostate	
Major findings of operation: Cerebral hemorrhage Heart, in Kidneys.	
Of autopsy: 131a	

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: C. B. Collins (M. D. or other)
Address: 3197 E. College Date signed: 7-1-43

SUPPLEMENTARY