

No. 2
 M-9-4-41
 Rev. 5-17-39
 I X2948A

DEPARTMENT OF HEALTH
 STATE BOARD OF HEALTH
 FILED OCT 1944

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

30624

State File No. _____
 Registrar's No. 310

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:
 (a) County Calloway
 (b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hospital no 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 yr 2 mo 9 days
(Specify whether years, months or days)
 In this community same

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Boone
 (c) City or town Columbu
(If outside city or town limits, write "RURAL")
 (d) Street No. 1022 North 4th
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME NANNIE B REED

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 18
 year 1944 hour 12⁴⁰ minute _____ M.

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

21. I hereby certify that I attended the deceased from Sept 1
 _____, 1944, to Sept 18, 1944
 that I last saw her alive on Sept 18, 1944
 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Dec (Month) 14 (Day) 1878 (Year)

Immediate cause of death: Chronic myocardium
 Duration _____

8. AGE: Years 65 Months 9 Days 4 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace: Boone County Mo (City, town, or county) (State or foreign country)
 10. Usual occupation: Domestic

Other conditions: Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

MOTHER FATHER
 11. Industry or business _____
 12. Name J. A. Reed
 13. Birthplace Boone Co Mo (City, town, or county) (State or foreign country)
 14. Maiden name Georgia Corne Morrow
 15. Birthplace Boone Co Mo (City, town, or county) (State or foreign country)

Major findings: Of operations _____
 Of autopsy 93d
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Records
 (b) Address State Hospital no 1
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (Month) (Day) (Year)
 (c) Place: burial or cremation Columbu Mo

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? _____

18. (a) Signature of funeral director Rouelle
 (b) Address Columbu Mo
 19. (a) 9-18-1944 (Date received local registrar) (b) Jose Moravichoff (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature R. E. Shurel (M. D. or other) M.D.
 Address Fulton Mo Date signed 9-17-44

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

4
 1
 2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-5-44

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.....

Em Balmer

....., Registered Apprentice No.....

working under my personal supervision.

Signed

R. O'Connell

Licensed Embalmer No. 3183

P. O. Address Columbia, Mo

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.