

7. S. No. 2  
DM-9.4-41  
rev. 5-17-39  
P.I. X29484

31551

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. ....

FILED SEP 12 1944

Registration District No. ....

Primary Registration District No. ....

5986

78

1. PLACE OF DEATH:

(a) County **Pulaski**  
(b) City or town **Tavern Township**  
(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 **1 yr.**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pulaski**  
(c) City or town **Crocker, Mo. (Rural)**  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME

**Harrison H. Reed**

3. (b) If veteran, name war **World War 1** 3. (c) Social Security No. ....

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Eulah Belle Reed** 6. (c) Age of husband or wife if alive **33** years  
7. Birth date of deceased **February 29 1896**  
(Month) (Day) (Year)

8. AGE: Years **48** Months **5** Days **21** If less than one day hr. .... min. ....

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

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Frank Reed**  
13. Birthplace **Maries Co. Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Anna Carroll**  
15. Birthplace **Maries Co. Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Eulah Reed**  
(b) Address **Crocker, Missouri**

17. (a) **removal** (b) Date thereof **Aug 24 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cem. Springfield, Mo.**

18. (a) Signature of funeral director **J. H. Hoops & Sons**

(b) Address **Crocker, Mo.**

19. (a) **8-21-1944** (b) **Chas. M. Reed**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **20** year **1944** hour **9** minute **A.M.**

21. I hereby certify that I attended the deceased from **Aug 18** 19 **44** to **Aug 20** 19 **44**  
that I last saw him alive on **Aug 19** 19 **44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis**  
Due to **Arteriosclerosis**  
Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations **940**

Of autopsy .....

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

23. Signature **P. W. Walleffe** (M. D.)  
Address **Crocker, Mo.** Date signed **9/21/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8500

SEP 13 1944

SEP 18 1944

**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

*Paul B. Hoop*

Licensed Embalmer No. *3261*

P. O. Address

*Crocker M.*

**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.**