

FILED JAN 16 1948  
128

Registration District No.

Primary Registration District No. 5465

926

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Rural; N. Campbell Twp. Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Pearl Nursing Home Rm 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 Months  
(Specify whether years, months or days)  
In this community 6 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2447 National Ave  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 16  
year 1944 hour 3 minute 15 P.M.  
21. I hereby certify that I attended the deceased from I had seen this man but did not treat him.  
that I last saw him alive on December 19  
and that death occurred on the date and hour stated Cerebral  
Duration

Immediate cause of death Cerebral hemorrhage  
Duration sudden

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) \_\_\_\_\_  
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) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature W. Murch (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 12, 17

3. (a) PRINT FULL NAME Christ C. Reid

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower

6. (b) Name of husband or wife UNK. 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased March (Month) 22 (Day) 1858 (Year)

8. AGE: Years 86 Months 9 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Benjamin P. Reid

13. Birthplace Unknown (City, town, or county) Mo. (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Florence R. Ellis

(b) Address 2447 N. National, Spfld. Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-21-48 (Month) (Day) (Year)

(c) Place: burial or cremation Richland, Mo.

18. (a) Signature of funeral director Tred Prime

(b) Address 1100 Boonville Ave. Spfld. Mo.

19. (a) 15-18-44 (Date received local registrar) (b) W. Murch (Registrar's signature)

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

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**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 Fred C. Thieme  
Licensed Embalmer No. 2899  
P. O. Address Springfield, 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.**

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