

Registration District No.

Primary Registration District No.

FILED FEB 24 1945  
208

5761

54

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Marion Liberty  
(c) Name of hospital or institution: P.S.P. Hospital  
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)  
In this community 1 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion 64  
(c) City or town 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

Louisa Elizabeth Reed

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John W

6. (c) Age of husband or wife if alive 19 years

7. Birth date of deceased April (Month)

19 (Day) 1867 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>25</u>	br. mil.

9. Birthplace

Hall (City, town, or county) IL (State or foreign country)

10. Usual occupation

11. Industry or business

Retired

12. Name

Fred E Pker

13. Birthplace

Germany (City, town, or county) (State or foreign country) 4

14. Maiden name

UNKNOWN

15. Birthplace

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

16. (a) Informant

Fred Reed

(b) Address

P.S.P. Hospital MO

17. (a)

Burial (Burial, cremation, or removal)

(b) Date thereof Jan. 16, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation

MT Olive Cem.

18. (a) Signature of funeral director

James O'Daniel

(b) Address

Marion MO

19. (a)

1-16-45 (Date received local registrar)

Mrs. Margaret Maddy (Registrar's signature)

Signature A. H. Sullivan (M. D. or other)

Address Calumet MO

Date signed 1/26/45

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13 year 1945 hour 8 P. minute M.

21. I hereby certify that I attended the deceased from Dec 29, 1944 to Jan 12, 1945 that I last saw her alive on Jan 12, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Parenchymatous Nephritis  
Due to Glomerular and tubular leakage

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

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

4000

1145

**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. *3246*

P. O. Address..... *Hannibal 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.**