

FILED MAY 16 1945

State File No. ....

Registration District No. ....

Primary Registration District No. 5042

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Barry  
(b) City or town Rural Liberty  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 25 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County: Barry  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Exeter Mo R# 1  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Sarah Francis Reed

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife William J Reed  
6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased March 21 1862  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15  
year 1945 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 28 1942 to April 15 1945  
that I last saw him alive on April 14 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Arterio sclerosis  
Valvular heart disease 3 yrs.

8. AGE: Years 83 Months \_\_\_\_\_ Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER  
12. Name William Stinson  
13. Birthplace Ky  
(City, town, or county) (State or foreign country)  
14. Maiden name Caleo Esperson  
15. Birthplace Ky  
(City, town, or county) (State or foreign country)

16. (a) Informant Medicine England

(b) Address Exeter Mo R# 1

17. (a) Burial (b) Date thereof 4 17 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cassville, Mo

18. (a) Signature of funeral director Wm Mans Boyer

(b) Address Wheaton Mo

19. (a) April 17-1945 Grace Williams  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 92d  
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) \_\_\_\_\_

(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? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature John R Ellum (M. D. or other) do

Address Wheaton Mo Date signed 9-6-45

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

1047

RECEIVED

District Health Officer No. 6,

District File Number 545-580

Date Filed MAY 14 1945

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 *Wm. Marcus Payne*

Licensed Embalmer No. *7492*

P. O. Address *Wheaton, 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.