V. S. No. 2
50M—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED AUG 9 1945

23610

State File No.

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 218

14
1
2

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

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 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 years 8 days (Specify whether
In this community same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 14

(c) City or town St Louis 1
(If outside city or town limits, write "RURAL")

(d) Street No. 5001 Cotes Ave 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME EVELYN 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 widow

6. (b) Name of husband or wife DK

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days If less than one day hr. min.

9. Birthplace Lincoln Co (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Masseuse

11. Industry or business

FATHER
12. Name DK
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Records State Hosp No 1
(b) Address Fulton Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-11-45 (Month) (Day) (Year)
(c) Place: burial or cremation Montgomery City Cem

18. (a) Signature of funeral director C W Hoffman
(b) Address Montgomery City Mo

19. (a) 7-11-1945 (Date received local registrar) (b) Jesse Morsenkopf (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1945 hour 1 minute 30 P M.

21. I hereby certify that I attended the deceased from July 8, 1945, to July 8, 1945
that I last saw her alive on July 8, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrenous Colon with Peritonitis

Due to Mechanical Valvulus

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy same

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1200

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? (e) Means of injury

23. Signature P P Price MD (M. D. or other)

Address Fulton Mo Date signed 7/9/45

1147 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 8-7-45

AUG 10 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 on the 9th day July 1945, Registered Apprentice No.....,
working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 1457

P. O. Address Martinsburg Ohio

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.