

S. No. 2
DM-8-43
v. 5-17-39
X37823

23768

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 4 1945
Registration District No. 74

Primary Registration District No. 3012

Registrar's No. 95-

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Excelsior Springs Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community Nine Hours
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ray
(c) City or town Richmond
(If outside city or town limits, write "RURAL")
(d) Street No. 201 East Main St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME William Levan Reed
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 22
year 1945 hour 9 minute P. M.

4. Sex Male () 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years (Day) (Year)

21. I hereby certify that I attended the deceased from July 22, 1945 July 22-45
that I last saw him live on July 22, 1945
and that death occurred on the day and hour stated above.
Immediate cause of death: Thyroid Enlargement
Duration

8. AGE: Years Months Days If less than one day
-- -- -- hr. 9 Hrs. min.

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death).....
Major findings: Of operations.....
Of autopsy.....

9. Birthplace Excelsior Springs Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business.....

PHYSICIAN
Underline the cause to which death should be charged statistically.
64

MOTHER FATHER }
12. Name C. J. Reed
13. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mayzee Thurman
15. Birthplace Atlanta Mo.
(City, town, or county) (State or foreign country)

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?.....

16. (a) Informant C. J. Reed
(b) Address Richmond Mo.
17. (a) Burial (b) Date there July 23, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place burial or cremation Richmond, Mo.
18. (a) Signature of funeral director Thurman
(b) Address Richmond Mo.
19. (a) T-23-45- (b) Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

23. Signature E. B. Gay (M. P. or other) 7/25-45
Address Richmond Date signed.....
While at work..... (Specify type of place) (e) Means of injury.....

1166 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8/3/45

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, ~~###~~

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *E. M. ...*

Licensed Embalmer No. 2073

P. O. Address Richmond, 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.