

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1235 N. JEFFERSON 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **GEORGE BLONDELL REED.**

3. (b) If veteran, name war **NONE**
3. (c) Social Security No. **491-03-5261**

4. Sex **MALE**
5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ETHEL REED**
6. (c) Age of husband or wife if alive **36** years

7. Birth date of deceased: **FEBRUARY 15-1886**
(Month) (Day) (Year)

8. AGE: Years **60** ~~59~~ Months **5** Days **16**
If less than one day hr. _____ min. _____

9. Birthplace **Greene Co. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Shoe Salesman**

11. Industry or business **Peters Shoe Co.**

12. Name **James P. Reed**

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

14. Maiden name **Elizabeth Warren**
(City, town, or county) (State or foreign country)

15. Birthplace **Ind. Ia.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ethel Y. Reed**
(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **Aug 2-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mapel Park J.W. Kingree & Co**
(d) Signature of funeral director **SPRINGFIELD MO.**
(e) Address **8-2-45** (f) Registrar's signature **S. W. Handley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE ?**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **1935 N. JEFFERSON**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **31**
year **1945** hour **6** minute **30 A.** M.

21. I hereby certify that I attended the deceased from **Jan 15 1945** to **July 31 1945**
that I last saw him alive on **July 30 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Colon** Duration **6 mo**

Due to **Metastases to peritoneum**

Due to **Bladder**
with resultant anemia 2 mo

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations **Imoperable adheant carcinoma of sigmoid colon**
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Robert Elym** (M. D. or other) **MD**
Address **Spfld, Mo.** Date signed **8/2/45**

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

2.

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MAY 11 1949

OCT - 8 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

May Rhodes

Licensed Embalmer No. *49710*

P. O. Address *Springfield*

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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