

1 X12873

FILED SEP 21 1945

Registration District No.

Primary Registration District No. 4552

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

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mountain Grove
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 68 Years
In this community 68 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright // 4
(c) City or town Mountain Grove
(If outside city or town limits, write "RURAL.")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or-No)
If yes, name country

3. (a) PRINT FULL NAME William M. Reed

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ida M. Reed 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased November 21 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 6 9 ..hr.min.

9. Birthplace McMinn County Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer (Retired)

11. Industry or business

MOTHER FATHER { 12. Name Baxter Reed
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Nancy C. Frey
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ida M. Reed
(b) Address Mountain Grove Mo
17. (a) Burial (b) Date thereof 6/1/1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Stubbs Cemetery

18. (a) Signature of funeral director Wm. Steffe
(b) Address Mountain Grove Mo
19. (a) 8-2-45 (b) H. M. Lower
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1945 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from Apr. 15 - 1945 to May - 30 - 1945;
that I last saw him alive on May 29 - 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Occlusion
Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 940
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? (e) Means of injury
23. Signature Wm. Steffe (M. D. or other)
Address Mountain Grove Mo Date signed 6-1-45

1333

RECEIVED
District Health Officer No. 6,
District File Number 945-962
Date Filed SEP 19 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 George Stapp
Licensed Embalmer No. 3161
P. O. Address W. H. Stone Rd.

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.