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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2532

FILED JAN 28 1946

Registration District No. 8 | Primary Registration District No. 5324 | Registrar's No. 8

1. PLACE OF DEATH:

(a) County: Crawford County

(b) City or town: Rural (Around Hey) (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 ____ In this community: All his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Crawford

(c) City or town: Bourbon Rural (If outside city or town limits, write "RURAL") BOONE

(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 Andrew Reed

3. (b) If veteran, name war: None

3. (c) Social Security No. ____

4. Sex: Male

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Emeline Reed

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

7. Birth date of deceased: July (Month) 25th. (Day) 1868 (Year)

8. AGE: Years 77 | Months 5 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace: Franklin Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: ____

FATHER
12. Name: John D. Reed
13. Birthplace: Missouri, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Lucinda Reed
15. Birthplace: Missouri, (City, town, or county) (State or foreign country)

16. (a) Informant: Celesta George
(b) Address: Sullivan, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-2-1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Crow Cemetary

18. (a) Signature of funeral director: J. T. Williams
(b) Address: Sullivan, Mo.

19. (a) 1-2-46 (Date received local registrar) E. E. Long (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 31st year 1945 hour 2 P.M. min. ____ A.M.

21. I hereby certify that I attended the deceased from Dec 1, 1945 to Dec 31, 1945 that I last saw him alive on Dec 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis — Duration: years

Due to: ____

Due to: with Glaucoma — years

Other conditions (Include pregnancy within 3 months of death): Cataracts

Major findings:
Of operations: ____
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: [illegible] (M. D. or other)
Address: Sullivan Mo. Date signed 1/2/46

(Licensed Embalmer's Statement on Reverse Side)

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

10114

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.....

Licensed Embalmer No. 427

P. O. Address Sullivan, 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.