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M-8-43  
7. 5-17-39  
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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. 16173

FILED JUN 13 1946

Registration District No. 98

Primary Registration District No. 4160

Registrar's No. 51

1. PLACE OF DEATH: -

(a) County Davies  
(b) City or town Winston Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

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

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community all of his life years, months or days  
Specify whether

3. (a) PRINT FULL NAME Robert Alongo Reid

3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, widowed

(b) Name of husband or wife Emma Reid  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 15 1865  
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 0  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired Rail Road Engineer

11. Industry or business

12. Name Daniel Reid

13. Birthplace Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Miller

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Leo Reid

(b) Address Winston Mo.

17. (a) Burial (b) Date thereof 5 19 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winston Mo.

18. (a) Signature of funeral director Mrs. Kate Shoup

(b) Address Winston Mo.

19. (a) May 28 1946 (b) Luquino M. Engshert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Davies  
(c) City or town Winston  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 15  
year 1946 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from March 1946 to May 15 1946  
that I last saw him alive on May 15 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Serility  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions 1628  
(Include conditions within 3 months of death)

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 Fred K. Wilson (M. D. or other) \_\_\_\_\_  
Address Winston Mo. Date signed May 17 46

15065  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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DISTRICT HEALTH OFFICE  
Cameron, Mo.

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 L. O. Richerson

Licensed Embalmer No. 3307

P. O. Address Callaway, 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.**