

Registration District No. 120

Primary Registration District No. 4194

Registrar's No. 98

1. PLACE OF DEATH:

(a) County Gentry

(b) City or town Albany
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte

(c) City or town Dearborn
(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 Mattie Reid

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

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

6. (b) Name of husband or wife B.F. Reid 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 11 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

83 3 15 hr. min.

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name William Sallee Muk 9

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

14. Maiden name Josephine Hunter Muk 9

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

16. (a) Informant Mrs. Frank Rose

(b) Address Albany, Missouri

17. (a) Burial (b) Date thereof Sept. 27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dearborn? Mo. Masonic

18. (a) Signature of funeral director Walter Smith

(b) Address Albany, MO

19. Sept 28-46 (b) Walter N. White
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25
year 1946 hour 11 minute 15 P. M.

21. I hereby certify that I attended the deceased from Sept. 20 1946, to Sept 25 1946
that I last saw him or alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary artery Thrombosis 1 wk.

Due to myocarditis 7 yrs.

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 93D

Of autopsy _____

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 Frank H. Rose (M. D. or other) M.D.

Address Albany, Mo. Date signed 9-26-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

OCT 30 1946

MAR 24 1947

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 Mo

....., Registered Apprentice No.
working under my personal supervision.

Signed

Leiford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany, 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.